

# **Responses of Child Welfare Organisations in KwaZulu-Natal to the challenges of HIV/AIDS**

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## **Declaration of Originality**

I hereby declare that this dissertation, unless specifically indicated to the contrary in the text, is my own work.

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Submitted with the approval of the supervisor, Professor Vishanthie Sewpaul.

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## **ABSTRACT**

Child Welfare organisations in South Africa, including KwaZulu-Natal, are being faced with various challenges. Since 1994, after the first democratic elections in South Africa, a major shift toward the developmental welfare approach was advocated in the White Paper for Social Welfare (Department of Welfare, 1997), in the provision of welfare services and programmes.

The South African AIDS epidemic shows no signs of halting. At present, South Africa has the largest number of individuals living with the virus in a single country, with an estimated 5.3 million infections (UNAIDS, 2005). KwaZulu-Natal is ranked fourth. South Africa is facing an unprecedented AIDS crisis. The increasing numbers of HIV infected adults and children are having a devastating impact on child welfare organisations.

Child Welfare organisations were already under- resourced, overstretched and overburdened, even before the AIDS epidemic emerged. The consequences of apartheid, especially in terms of mass poverty and HIV/AIDS add a further problem on an already divided and somewhat 'abnormal' society. In addition, the shift from the welfarist tradition of social work practice to the developmental paradigm has serious implications on the functioning of child welfare organisations, which are unable to cope with the existing caseloads. Hence there is a need to address the challenges and for specialised services in the arena of HIV/AIDS. The purpose of this study was to investigate the responses of child welfare organisations in KwaZulu-Natal to the challenges of HIV/AIDS. The eco-systems perspective provided the theoretical framework within which the study was conducted. This perspective guided the selection of the study samples and the analysis of data. The study adopted a descriptive design, and the triangulated research paradigm incorporating both the quantitative and qualitative methods, as this was the most appropriate approach for the study's focus, objectives and research questions. By combining these two methods, a general

overall audit was achieved in addition to obtaining rich, in-depth information. Fifty-five child welfare organisations in KwaZulu-Natal constituted the main sample for the quantitative study. Personal in-depth interviews were conducted with 5 senior social work personnel from the child welfare organisations.

There were conclusive findings in this study that indicated that overall, child welfare organisations in the KwaZulu-Natal region are making concerted efforts to respond to the challenge of HIV/AIDS in the broad areas of policy implementation and modification, specific programmes for children, special facilities for children affected by HIV/AIDS, awareness and prevention programmes and community projects. However difficulties in these areas were also experienced in the specific areas of providing adequate care, support and counselling with regard to children and families infected and affected by HIV/AIDS, staff inadequacy and training and facilities for pre and post test counselling.

Some of the factors that have been responsible for impeding the overall success can be attributed to: high staff turnover, high caseloads, burnout and stress, lack of adequate resources, inadequate funding, lack of government support, poverty and inefficiency in the social security system. Recommendations for further research and for policy and practice are detailed.

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# PART ONE

## **PART ONE - INTRODUCTION**

### **Chapter One**

#### **CONTEXT AND PURPOSE OF STUDY**

##### **Introduction**

The latest global AIDS figures show some signs of hope, in that adult infection rates have decreased in a few countries notably in Kenya, Zimbabwe and some Caribbean countries. However, it is important to note that at present, South Africa has the largest number of individuals living with the virus in a single country, with an estimated 5.3 million infections (UNAIDS, 2005). This is a real shocking fact if we take into account that 10% of all the estimated HIV infected individuals in the world are in South Africa, while South Africa constitutes only 0.68% of the world population (Dyk, 2003).

South Africa is facing an unprecedented AIDS crisis. The alarming increase of families and children infected and affected by HIV/AIDS is impacting on child welfare organisations in ways one cannot even begin to imagine. Tremendous strains are being placed on traditional methods of childcare. Whilst the family is still an important care provider in South Africa, its functioning as a mutual support system has been severely strained by decades of migrant labour, the policies of apartheid, poverty and other social ills. As the AIDS epidemic is increasing at an alarming pace in South Africa, it is inevitable that an even higher increasing numbers of children will fall through the extended family safety net.

Child welfare organisations were already under- resourced, over-stretched and over-burdened even before the AIDS epidemic emerged. In addition to the challenge of HIV/AIDS, child welfare organisations are being faced with changes



in National Welfare Policy as contained in the White Paper for Welfare (Department of Welfare, 1997), which promotes a shift from the welfarist tradition of social work practice to a more developmental paradigm. The developmental approach has serious implications for the functioning of child welfare organisations, especially in the HIV/ AIDS context. The two key components of the welfare policy are:

- a) that individuals and communities must play an active role in the promotion of their own well being,
- b) The emphasis on maximising existing potential indicates that child welfare organisations must render services within a climate of financial restraint due to lack of adequate funding (Department of Welfare: 1997).

It is also important to mention that the ideas for the transformation of the South African Welfare policy in the post apartheid era was integrated in the RDP (Reconstruction and Development Programme). The RDP was designed to address the inequalities of the past which included public investment as a means to promote development and employment, and taxation to foster the redistribution of wealth and increased government borrowing which could be used for social spending including welfare (Patel, 2005).

However, the RDP was replaced by GEAR (Growth, Employment and Redistribution) in 1996 due to a collapse in the currency. This approach represents a distinct shift from RDP in that it restricts government spending on social services and allows for no major increases in taxation (Sewpaul and Holscher, 2004). This is especially critical for child welfare organisations, which are poorly funded, as the full socio-economic impact of HIV/AIDS will present challenges to service delivery, which is already pressured, by high caseloads, inadequate resources and lack of government funding and support. The critical importance of the welfare policies were clearly ingrained in the researcher's consciousness when assessing the responses of the child welfare organisations to the challenge of HIV/AIDS. Child welfare organisations have to deal with the

ever-increasing children orphaned as a result of HIV/AIDS against the impact and consequences of GEAR. There exists no doubt that the HIV/AIDS epidemic has placed various demands and challenges on child welfare organisations, which are already overburdened and unable to cope with the demands of the caseloads. Hence there is a need to address these challenges and there is a need for specialised services in the area of HIV/AIDS.

The number of orphans is increasing dramatically which results in heavy caseloads for the social workers, made worse by high staff turnovers. This makes it difficult for the organisations to offer services other than the most basic ones. Very often work is focused on helping caregivers to access financial support through drawn out statutory procedures and there is seldom time for more extensive measures such as counselling for the child (Elm and Haraldsson, 2006). One critical concern is whether the existing welfare policy is appropriate and adequate for child welfare functioning and effective service delivery.

In the South African context, the child welfare organisations are already burdened with the consequences of apartheid, which has resulted in a divided and unequal society especially in terms of mass poverty. HIV/AIDS adds a further problem on an already divided and somewhat 'abnormal' society. Thus the broad aim of this research was to investigate the various responses of child welfare organisations in the KwaZulu-Natal region to the challenge of HIV/AIDS.

### **Statement of the Problem**

When AIDS emerged two decades ago, it was difficult to predict how the disease would evolve. Since the first clinical evidence of AIDS was reported, AIDS has become the most devastating disease facing humankind. The latest statistics on the world epidemic of AIDS and HIV as at the end of 2005 indicated that 40.3

million people were living with HIV/AIDS worldwide. A total of 4.9 million people were newly infected with HIV and the AIDS deaths totaled 3.1 million in 2005 despite recent improvements in access to antiretroviral treatment. It was also reported that more than 25 million people have died of AIDS since 1981 and Africa has 12 million orphans as a result of the disease. Of significance was that young people between 15 and 24 years accounted for half of all new infections worldwide and more than 6000 people become infected with HIV every day. In Sub-Saharan Africa, 25.8 million adults and children were living with HIV/AIDS, of which the new infections as per the end of 2004 amounted to 3.2 million alone (UNAIDS, 2005). HIV/AIDS is now the leading cause of death in sub-Saharan Africa and worldwide it is the fourth biggest killer (Dyk, 2003).

Detailed statistics for global figures and Africa is incorporated in Part Two, Chapter Two.

AIDS is the acronym for Acquired Immune Deficiency Syndrome. AIDS can be defined as a disease (Houle, 2003). "Although we use the term 'disease' when we talk about AIDS, AIDS strictly speaking is not a specific illness. It is a collection of many different conditions that manifest in the body's immune system that it can no longer fight the pathogens that invade the body. It is therefore more accurate to define AIDS as a syndrome of opportunistic diseases, infections and certain cancers, each or all, which has the ability to kill the infected person in the final stages of the disease"(Wyk, 2001:4-5).

HIV infection is first and foremost a biomedical condition. HIV is one of a family of retroviruses that enters the bloodstream and attacks the body's immune system, compromising its ability to fight infections. Two basic strains of HIV have been discovered each with their associated subtypes. HIV-1 is the most common virus strain and is found principally in the First World, Asia, Latin America and most of Africa. HIV-2 is geographically linked to West Africa, although HIV-2 cases have been reported in Mozambique, and is thought to be present in KwaZulu-Natal.

HIV-1 is a more virulent strain than its counterpart and has a shorter incubation period. A cause for concern among virologists is that both virus strains mutate and it is possible for one type to transform itself into another within the infected person. Thus, to date, attempts to find a vaccine or a cure have eluded the scientific community (Whiteside et al, 1995:4).

In order to develop, HIV has to enter the bloodstream, the main routes of transmission from one individual to another being through sexual contact, from contact with infected blood or from an infected mother to her unborn or newly born child (Whiteside, 1995:3). Once infected with HIV, a person is labeled 'HIV positive' and carries the virus for the remainder of his or her life. At the point of infection, a battle begins between the virus and the body's immune system. The battle proceeds through four stages before the person dies (Dyk, 2001).

The manifestation of AIDS is similar throughout the world, but there is age, gender and regional differences in the presentation of the disease as stated by Fleming (cited in Pillay, 2003:2). AIDS has become a full-blown development crisis and its consequences are felt widely across all sectors of the country (Dyk, 2003). The length of time from the HIV infection to the development of AIDS varies greatly, and is dependent on an individual's general state of health, socioeconomic condition, age and access to various resources in society such as health care. In less developed countries individuals have less access to medical, health and welfare resources, thus resulting in a devastating impact on the communities as a whole.

### **Context of the Study**

The Republic of South Africa is a comparatively large country, covering 1,221,042 square kilometers and with an estimated population of about 40 million. Twenty eight percent of people in South Africa have been affected by

HIV/AIDS, and 13% of the forty million of all the people in the world living with HIV can be found in South Africa. UNAIDS estimates that at the end of 2003 there were 5.3 million people in South Africa living with HIV, which is 21.5% of the population.

The country is comprised of large, crowded cities and sparsely populated rural areas. The average density of the population is approximately 29 people per square kilometer, with 59.5% of these in urban areas and 40.5% in rural areas. Some parts of the country, especially in the rural areas, are very isolated and underdeveloped. This lack of infra-structure is one of the several factors that make it difficult to get a clear picture of the size of the population and the HIV/AIDS prevalence.

A common method of measuring HIV prevalence in South Africa is by looking at HIV test results taken from pregnant women who attend antenatal clinics. Some areas of South Africa, however, lack antenatal facilities and many women will not have the opportunity to see a midwife during their pregnancy or to take a HIV test. There has also been criticism that this method of measuring prevalence only gives a picture of HIV rates amongst sexually active women, some of whom, due to stigmatisation experienced by people with HIV, are naturally reluctant to have the test.

A survey published in March 2004, shows that South Africans spend more time at funerals than they do having their haircut, shopping or having Bar-B-Q's. It is estimated that about 600 people in South Africa die of HIV-related illnesses each day.

Historically, South Africa has had a turbulent past, and this history is relevant to the explosive spread of HIV in the region. In the province of KwaZulu-Natal, where the study was conducted, the number of orphans in 2003 was estimated to

be about 275 000 which is approximated to increase to almost half a million by 2010 (Singhal & Rogers 2003).

The statistics discussed here come from two prevalence studies that estimate how many people have HIV, and two reports on AIDS deaths. Viewed together these sources give an idea of the scale of South Africa's HIV epidemic. The first is based on the report of the Department of Health 'National HIV and Syphilis Sero-prevalence Survey in South Africa 2004', published in 2005. This is the 15<sup>th</sup> in a series of studies, which look at data from antenatal clinics and use it to estimate HIV prevalence in pregnant women. The report also contains an estimate of the total number of people living with HIV in South Africa, derived from the antenatal data using a simple mathematical model.

Based on its sample of more than 16,000 women attending antenatal clinics across nine provinces, the South African Department of Health Study estimates that 29.5% of pregnant women were living with HIV in 2004. The provinces, which recorded the highest HIV rates, were KwaZulu-Natal, Gauteng and Mpumalanga. Because infection rates vary between different groups of people, the findings from antenatal clinics cannot be applied directly to men, newborn babies and children. However, some simple calculations can yield an approximate estimate of the total number of people living with HIV in South Africa.

Based on the antenatal data, the study estimates that 6.29 million South Africans were HIV positive at the end of 2004, including 3.3 million women and 104,863 babies. In producing these figures, it is assumed that pregnant women accurately represented all women aged 15-49 years, that men were 85% as likely to be infected as women, and that 30% of babies born to infected mothers would themselves be HIV positive.

The second study is based on the report of the "Nelson Mandela/HSRC Study of HIV/AIDS, 2002". This study is based on a household survey and involves sampling a proportional cross-section of society, including a large number of people from each geographical, racial and other social group. The surveyors take great pains to try to make the sample as generalised as possible, and the findings are later adjusted to correct for likely over or under representation of individual groups (according to census data).

In total, 14,450 people were selected to take part in the study, and surveyors managed to visit 13,518 of them. Just 8,840 people agreed to give samples of oral fluid, which was taken for anonymous testing, which means that one in three refused. One reason for such a low level of cooperation could be that South Africans are generally reluctant to take part in surveys, partly due to fear of crime. Another possible reason could be attributed to the fact that the subjects knew they were likely to give a positive result. The 65% response rate is considered "good" by the standards of this type of survey, but it is considerably lower than that found in other parts of sub-Saharan Africa.

Some of the samples collected were unusable. The final number of test results was 8,428. Based on these results, the study estimates that 11.4% of all South Africans over the age of 2 years were HIV positive in 2002. Among those between 15 and 49 years, the estimated prevalence rate was 15.6% in 2002. The results of this study suggest that KwaZulu-Natal does not have the highest HIV prevalence, as was previously thought, but ranked fourth.

The third report looks at AIDS-related deaths using data from death certificates. In February 2005, the South African government and Statistics South Africa published the report "Mortality and causes of death in South Africa, 1997-2003". This large document contains lists of how many people died from each cause over a six-year period, according to death notification forms. The government's report reveals that the annual number of registered deaths rose by a massive

57% between 1997 and 2002. Among those aged 25-49 years, the rise was 116% in the same six-year period. Part of the overall increase is due to the population growth and more complete reporting of deaths. However, this does not explain the substantial rise in the proportion of deaths occurring among persons aged 25 to 49 years. In 1997, people in this age group accounted for 23% of all deaths, but in 2003 they made up 34%.

When analysing the results of the 3 surveys it is very clear that this confirms the findings by Whiteside and Sunter (2001) and Alpaslan and Mabutho (2005) that it is the reproductive age group that is hardest struck by the pandemic, resulting in the loss of great parts of the parenting generation. The deaths as a result of the HIV/AIDS pandemic is impacting on child welfare organisations due to the increasing numbers of orphans and the absence of caregivers. Although there is no consensus regarding KZN having the highest prevalence in the country, it still has a high incidence of infections, which is reputed to be the fourth highest in the province. This background serves to explain the reasons for the researcher choosing the study within this context.

### **Rationale for the Study**

The main rationale for the study is justified against the backdrop of the shocking statistics available for HIV/AIDS especially for KwaZulu-Natal in particular, which is reputed to have one of the highest rates of prevalence in the country. In terms of one of the statistics available for 2002, it was estimated that over 204000 children were newly orphaned and that KZN accounted for 81% of them. Furthermore, it is estimated that the children who will be orphaned as a result of HIV/AIDS is likely to peak around 1.85 million by 2015. Presently, approximately 204000 children need to be taken care of due the death of their parents. This has a profound impact on child welfare organisations whose primary role is towards the well being of all children and their families. Caring for orphans, being the



most tragic and long term legacy of the epidemic, has presented one of the greatest challenges for child welfare organisations as they are already facing numerous other challenges i.e. readdressing the results of apartheid, mass poverty and high caseloads. Thus HIV/AIDS adds a further problem to an already overburdened and under-resourced welfare sector.

Brown (1981) states that the choice of research topics should be of profound interest for the researcher who will ensure and possess the desperately needed motivation to complete the study. This is applicable in the current study as the researcher is employed as a social worker in a child welfare organisation and has first hand knowledge regarding the functioning of child welfare organisations and the challenges facing them.

Besides the interest in the topic, which was not just to satisfy the researcher's personal curiosity, the purpose was to advance and add to the existing knowledge on the subject matter. Freudenthal (2001) reported on a review of Social Science research on HIV/AIDS in Africa indicating that there was a need for more research between AIDS and welfare.

## **Research Objectives**

The study was guided by the following objectives:

- ⌘ To investigate the responses of the various child welfare organisations in the KwaZulu Natal region to the challenge of HIV/AIDS
- ⌘ To investigate the policies that have been formulated and implemented to address the psychosocial and economic consequences of HIV/AIDS
- ⌘ To investigate the staff and training capacity to cope with HIV/AIDS in KwaZulu-Natal
- ⌘ To investigate the obstacles encountered by child welfare organisations in Kwa Zulu-Natal to the challenge of HIV/AIDS

## Research Questions

- ⌘ What are the responses of the child welfare organisations in the KwaZulu-Natal region to the challenge of HIV/AIDS?
- ⌘ What policies have been modified or implemented to address the psychosocial and economic consequences of HIV/AIDS?
- ⌘ What is the staff and training capacity to cope with HIV/AIDS in KwaZulu-Natal?
- ⌘ What programmes are available to children and their families affected by HIV/AIDS?
- ⌘ What facilities are provided for Pre and Post Test Counselling?
- ⌘ What facilities are provided for orphans?
- ⌘ What awareness or prevention programmes have been implemented?
- ⌘ What are some of the obstacles encountered by the organisations in KZN with regard to HIV/AIDS?

## Theoretical Framework

According to Homans (cited in Dejong, 1998), theories play a critical role in our understanding of reality and our ability to cope with problems. A theory is a set of interrelated propositions or statements, organised into a deductive system that offers an explanation of some phenomenon.

The eco-systems approach was viewed as the most appropriate framework to guide the study. Social demography is a vital component in terms of the relationship of child welfare organisations and HIV/AIDS. Social demography is concerned not merely with the dynamics of population size, composition and distribution but it also attempts to understand the ways in which population characteristics interact with social and natural forces. This theory suggests that

our population is one component among several of a highly interdependent social environmental systems (Craft et al, 1980).

The essential aspect of the eco-systems theory is the interdependent, reciprocal relationship that exists between the given elements. In this sense, population change is related to cause and effect to environmental, social, organisational, technical and cultural factors. Population is part of an interactive process involving society, culture, environment, and technology and through feedback and reciprocities, etc.

No one lives in a vacuum. An individual's HIV/AIDS status has a tremendous influence on the systems in which he or she exists and the affected person is simultaneously affected by these systems. AIDS may be likened to a stone dropped in a pool. Ripples from AIDS move to the very edge of society, affecting just one person, progressing to the family, then the community and finally the nation. In respect to child welfare organisations, an important function includes facilitating grant applications and rendering statutory supervision for children orphaned as a result of HIV/AIDS. This has a strong impact on the well being of the orphans especially within the climate of child welfare organisations, which are known to be underresourced and overburdened.

Because of these complex interdependencies, the application of the eco-systems perspective is an especially useful tool for sensitising oneself to social change and for guiding programmes and policies intended to affect change. This theory has applications in the specific problems and decisions that come to the attention of social service administrations.

The eco-systems view directs professional attention to the person-in-environment i.e. human problems develop as an outcome of transactions between the environment and people. This perspective serves to direct practice in 3 ways:

- 1) It restates the importance of understanding the effects of physical, social and cultural environments on the lives of individuals and families;
- 2) It encourages the development of social delivery;
- 3) It calls attention to change efforts designed to modify or restructure environments that produce stress on people (Peile, 1994).

### **Research Approach**

A detailed description of the Research Methodology is outlined in Part Three, Chapter Five.

Self-administered mailed questionnaires ranging from the structured to the unstructured format, and one-to-one interviews, were central to the selection of the study's research design and the formulation of the primary research questions.

The triangulated research paradigm, which incorporated both the quantitative and qualitative methods, was utilised, as this was the most appropriate approach for the study's focus, objectives and research questions. By combining these 2 methods a general overall audit was possible. In addition to obtaining rich, in-depth information from the 5 participants, 55 child welfare organisations in of KwaZulu-Natal were surveyed via mailed questionnaires using both open and closed-ended questions. By combining these 2 methods, it enriched the study and ensured that a maximum number of dimensions of the phenomena under study were tapped.

In this design, the researcher first collected the quantitative data for research, followed by obtaining qualitative data for the research separately and then integrated the information in the interpretation of the overall results.

The descriptive design was chosen over the exploratory design.. The descriptive design is also characterised by more systematic and rigorous techniques for sample selection and for collecting and analysing the data. Convenience sampling was used for the mailed questionnaires and is justified in this research in view of representativeness. All child welfare organisations in Kwa Zulu-Natal were included in this study. For the qualitative research, purposive sampling was used. For this study, statistical procedures were used to analyse the quantitative data. In a well-designed and well-conducted study, data are not over collected and they are well managed. This is indicative of this study whereby only 5 participants were incorporated as part of the interviewing process, which added to rich in-depth data necessary to enhance the overall goal of the research. The research approach designed to obtain a holistic understanding of the responses of child welfare organisations to the challenges of HIV/AIDS coheres with the eco-systems framework.

### **Assumptions of the Study**

The study had several underlying assumptions, which included:

- ⊗ As social workers from child welfare organisations are at the forefront in dealing with families and children, they and their organisations have been impacted by the HIV/AIDS challenge. It is assumed that the child welfare organisations are not responding positively with regard to HIV/AIDS in most areas.
- ⊗ Staff turnover is impacting negatively on service delivery and contributes to burnout and stress among social workers.
- ⊗ There is a lack of programmes available for children affected by HIV/AIDS
- ⊗ Child welfare organisations are struggling to initiate and sustain community projects
- ⊗ Lack of government funding and support seriously impacts service delivery

### **Value of the study**

In terms of policy, practice and recommendations that might emerge from the study, it is anticipated that the study can make the following contributions within the broad field of welfare. As the study's main purpose was to investigate the responses of child welfare organisations in the KwaZulu-Natal region to the challenge of HIV/AIDS, the findings will highlight:

- ⌘ The current status of child welfare organisations in adopting and amending their policies in order to address and cope with the pandemic.
- ⌘ Staff adequacy and training, programmes and facilities and obstacles encountered.
- ⌘ Aspects regarding research in the field of HIV/AIDS
- ⌘ Demographic differences of child welfare organisations
- ⌘ The functioning of child welfare organisations within the context of HIV/AIDS
- ⌘ How state policies might impact on child welfare organisation
- ⌘ Provision of adequate funding
- ⌘ Resource availability
- ⌘ Staff turnover
- ⌘ High caseloads and other service conditions

These aspects can assist child welfare organisations in ensuring effective service delivery and HIV/AIDS infected individuals will have better access to care and services.

### **Presentation of the Study**

This study is organised into five major parts and each part is further divided into separate chapters. Part One, Chapter One provides a broad overview of the

study. It outlines the introduction, rationale, purpose, theoretical framework, research approach, assumptions and value of the study.

Part Two comprises three chapters on literature reviews. Chapter Two focuses on the nature, extent and challenges of HIV/AIDS. Chapter Three discusses the functioning of child welfare organisations in South Africa and Chapter Four examines social security within the South African context.

Part Three, Chapter Five, provides an overview of the methodology used in the study. This chapter details the research strategy, sampling strategy, methods of data collection, and the analysis of data, issues of validity and reliability and ethical considerations. This chapter also highlights some of the limitations of the study.

Part Four consists of two chapters, Chapters Six and Seven, consisting of the analysis and discussion of the results. The findings are discussed in terms of the critical questions raised in these chapters and the literature reviewed in Part Two, Chapters Two, Three and Four.

The concluding part and chapter, Part Five, Chapter Eight, examines the final conclusions and recommendations relating to the research study.

# PART TWO



## **PART TWO: LITERATURE REVIEW**

### **Chapter Two**

#### **HIV/AIDS: NATURE, EXTENT AND CHALLENGES**

##### **Introduction**

HIV/AIDS is a human catastrophe unlike any other previously encountered by humankind. Now, at the beginning of its third decade, HIV/AIDS is one of the most devastating diseases of our time. Local, national and international efforts are needed to prevent the spread of HIV/AIDS and to break the silence that still continues to surround the disease in many countries. In South African society, where for many, basic day-to-day existence is already a struggle, AIDS is a heartless monster. The psychosocial and economic impact of the epidemic on individuals, families and communities are tremendous. It deepens poverty, sets back economic and social progress, inhibits further growth and is a threat to essential services. In addition to being a personal and human tragedy, HIV/AIDS affects every sector of society, both at a micro and a macro level. It impacts on the demographic profile of a country, on labour productivity and supply, it places pressure on the health, housing and education sector and also importantly on the welfare sector (UNAIDS 2004, UNICEF 2002, Guest 2001, Dyk 2001 and Patel 2005).

This chapter begins by describing and quantifying the problem, progressing into a discussion on the nature and extent of HIV/AIDS, the current trends regarding the global epidemic and international responses to the problem. The current crisis in Sub-Saharan and South Africa including KwaZulu-Natal is also explored. It also considers some of the reasons that have contributed to the rapid spread of

HIV/AIDS in South Africa and the socio-economic impacts of HIV/AIDS. Definitions and important concepts regarding HIV/AIDS have already been explored in Chapter One, thus the researcher has initiated this chapter by discussing the trans-mission of HIV with special relevance to South Africa.

### **The transmission of HIV**

Sexual intercourse is the principle mode of transmission, accounting for an estimated 75% of infections globally, of which 75% involve heterosexual intercourse and 25% sexual relations between men (Aids Foundation, 2002). In Third World countries, sexual transmission accounts for an even higher proportion of infections. The spread of the epidemic in societies where heterosexual intercourse is the main mode of transmission is largely dependant upon two main factors-the presence of other untreated sexually transmitted infections (STIs) and sexual behaviour. Therefore any attempts to reduce the spread of HIV must address these factors.

Blood-to-blood transmission occurs when HIV contaminated blood comes into direct contact with that of an uninfected person. The main transmissions occur through the sharing of intravenous drug-injecting equipment and through contaminated blood products used in transfusions. HIV transmission through blood transfusion services has been eliminated in the First World countries, where sophisticated screening mechanisms have been introduced to ensure that blood products are HIV-free but in Third World counties this remains an issue.

Mother-to -child transmission is one of the major causes of HIV infections and this occurs in two ways. It is estimated that 600 000 children are infected in this way each year. The first is at birth when the infant comes into contact with the blood of an infected mother. The second is through infant breastfeeding. It is estimated that about 50% to 65% of infections occur at birth. Since mother-to-

child transmission is a result of the heterosexual epidemic, infants in the Third World are at greatest risk, particularly in Sub-Saharan Africa. Globally, mother-to-child transmission accounts for about 10% of infections and 20% in Africa (UNAIDS, 2002).

### **Global Statistics and Responses**

The AIDS epidemic continues to outpace the global response. The disease has quadrupled since the first cases were recorded in the 1980s. Since then, 42 million people globally have been infected with the virus and almost half have died (Patel, 2005).

According to estimates from the Joint United Nations (UNAIDS, 2005) programmes on HIV/AIDS and the World Health Organisation (WHO, 2004), 15 million children were living with HIV at the end of 2004. Of significance is that about 70% is in Sub-Saharan Africa. The total number of infections for adults and children is more than 50% higher as projected by WHO in 1991 on the basis of the data available. They also reported that during 2004, 5 million people became infected with HIV and 3 million deaths occurred. This indicates a high global total, despite antiretroviral therapy, which reduced AIDS and AIDS related deaths in the richer countries. Deaths among those already infected will continue to increase for some years even if prevention programmes manage to cut the number of new infections to zero. However, with the HIV positive population still expanding the annual number of AIDS deaths can be expected to increase for many years (UNAIDS, 2005).

Around half of the people who acquire HIV became infected before they turned 25 and typically die before their 35<sup>th</sup> birthday. The age factor makes AIDS uniquely threatening to children. By the end of 2004, the epidemic left behind a cumulative total of 15 million orphans, defined as those having lost one or both

parents to AIDS before reaching the age of 15 (UNAIDS, 2005). In 2003, an estimated 700 000 children aged 14 or younger became infected with HIV, over 90% were babies born to HIV positive women, who acquired the virus at birth or through breastfeeding. Of these, almost 9/10ths were in Sub Saharan Africa. Africa's lead in mother-to-child transmission of HIV was firmer than ever (UNAIDS, 2005).

The overwhelming majority of people with HIV, some 95% of the global total live in the developing world of which 70% lives in Sub Saharan Africa. The proportion is set to grow even further as infection rates continue to rise in countries where poverty, poor health care systems and limited resources for prevention and care fuel the spread of the virus (UNAIDS, 2004).

Global responses to the HIV/AIDS epidemic have shown humanity at both its worst and its best. Although courage, care, commitment and compassion have come to the fore, denial, blind panic, victim blaming and lack of political will have been some of the worst responses.

Globally, turning back the AIDS epidemic will require a drastic and emergency response. UNAIDS itself exists as a unique entity, an HIV/AIDS programme that brings together the collective expertise and efforts of seven co-sponsoring organisations i.e. United Nations Children's Fund (UNICEF), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations International Drug Control Programme (UNDCP), United Nations Educational, Scientific and Cultural Organisation (UNESCO), World Health Organisation (WHO) and the World Bank.

However, the collective response to AIDS extends far beyond these boundaries and includes NGOS and community leaders. There has been an increase in the number of countries with comprehensive, multisectoral national AIDS strategies

and government led national AIDS coordinating bodies, but the existence of plans and bodies does not always translate into efficient and concerted action. In some countries, legislation has not kept up with policy and strategic planning whilst others have ratified international conventions on human rights but they have not been effectively implemented. National AIDS authorities are increasingly turning to formal partnership to stimulate civil society participation and increase national ownership of the response, but, much more needs to be done.

A recent assessment of Non-governmental Organisations (NGO) participation in the Global Fund's first round of grants showed government's commitment to working with NGOs appeared to be somewhat hollow (UNAIDS, 2004). Many appeared to cooperate with NGOs to secure funding and then lost interest in collaborating. Although there have been some signs of improvement of quality of care for people living with HIV/AIDS and some other major developments including antiretroviral medicines, there still exist huge challenges to turning the tide of the epidemic (Aids Review, 2004).

Sub-Saharan Africa remains by far the worst affected and is the most poorly resourced region in the world. An estimated 26.6 million people are living with HIV/AIDS and approximately 3.2 million new infections occurred in Sub-Saharan Africa in 2003. In 2004, the epidemic claimed the lives of an estimated 2.3 million Africans. Ten million young people (aged 15-24 years), almost 3 million children under 15 are living with HIV and an estimated 11 million children have been orphaned by AIDS (UNAIDS 2004).

Patterns of transmission vary, as do the populations most at risk. In this region, the virus spreads mainly through heterosexual intercourse in all social groups. Women's physiological, social and economic vulnerability, however, contributes to their higher rates of infection in this region. The true extent of the epidemic is becoming clear in many African countries, as increasing numbers of people with

HIV are becoming ill. In the absence of massively expanded prevention, treatment and cure efforts, the AIDS death toll on the continent is expected to continue rising before peaking around the end of the decade. This means that the worst of the epidemic's impact on these societies will be felt in the course of the next ten years and beyond. Its social and economic consequences are already being felt widely in health, education, industry, agriculture, transport, welfare human resources and the economy in general.

### **The Extent of HIV/AIDS in South Africa**

The Republic of South Africa is a comparatively large country, covering 1,221,042 square kilometers with an estimated population of about 40 million. The country is comprised of large crowded cities and sparsely populated rural areas. South Africa has approximately 4.5 million people infected with HIV, which is the greatest population of HIV of any country in Africa (Bradshaw and Johnson et al, 2002).

A common method of measuring HIV prevalence in South Africa is by looking at HIV test results taken from pregnant women who attend antenatal clinics. Some areas of South Africa however, lack antenatal facilities and many women will not have the opportunity to see a midwife during their pregnancy to take a HIV test. There also has been criticism that this method of measuring prevalence only gives a picture of HIV rates amongst sexually active women, some of who, due to the stigmatisation experienced by people with HIV are naturally resistant to having a test.

South Africa's first nationally representative study of HIV prevalence found that 11.4% of South Africans (4.5 million people) are living with HIV/AIDS. The prevalence among the age group of 15-49 years was 15.6% among females, 12.8% tested HIV positive while 9.5% of males tested positive. Among the youth

15-24 years, twice as many females ie.12% were infected compared to males, which was 6% (Human Science Research Council, 2002).

People living in urban areas and informal settlements were most at risk of contracting HIV with a prevalence of 21.3% and 12.1% respectively. The mobility and transient nature of life in informal settlements, rather than socio-economic factors makes those living in these areas more vulnerable (Human Science Research Council, 2002).

HIV prevalence amongst Africans was highest at 12.9%. This can be explained by historical factors as well as labour migration and relocation and the fact that more African people live in informal settlements. The infection rate among whites was 6.2%. This is considerably higher than countries with predominantly white populations such as the US, Australia and France where the prevalence rate amongst whites is less than 1%. Coloured prevalence was 6.1% and amongst Indians prevalence was 1.6% (South African Epidemiological Fact sheet, 2002).

The annual antenatal surveys have consistently found KwaZulu-Natal to have the highest prevalence, yet the nationally representative study found the province ranked fourth with an infection rate of 11.7%. A possible explanation for the discrepancy is the fact that the sites for KwaZulu-Natal's antenatal surveys are along major transport routes, which are known to be high-risk areas and the nationally representative study included rural households away from main roads. HIV prevalence was highest in the Free State (14.9%), Gauteng (14.7%) and Mpumalanga (14.1%). One possible reason is that Gauteng and the Free State have the highest proportion of their residents living in informal settlements, which is a significant risk factor for HIV (South African Epidemiological Fact Sheet, 2002).

The highest prevalence was among the 25-29 age group (28%), followed by the

30-34 group (24%). Prevalence among children between 2-14 was unexpectedly high at 5.6% (South African Epidemiological Fact Sheet, 2002). KwaZulu-Natal occupies about 92 000 square kilometers (one-tenth of South Africa's land surface). It is the country's third smallest province and the largest population of approximately 9.3 million accommodating about 20% of the total population of the country. Approximately 43% of KZN's population live in urban areas while the rest live in non-urban areas. The rural communities are strongly influenced by traditional authority structures and the communal administration of land and resources are common.

The reasons for the rapid spread of the epidemic in KwaZulu-Natal further and faster than the rest of the country has been given by Whiteside et. al (1995). These include poor skills, lack of employment whereby less than half of the labour force is employed in this region and more than 1 million people are without jobs, high levels of poverty and labour migration leading to disrupted family life. Those factors can be added to the existence in the province of two large ports and a number of major national and international road and rail transport routes. KZN has also experienced many years of violent political conflict, which is a further contributing factor to the rapid spread of HIV/AIDS. However as KwaZulu-Natal is a province of South Africa, its functioning is dependent on the policies applicable to South Africa as a whole (Whiteside et al, 1995).

Terreblanche cited in Sewpaul and Holsher (2004:2-3) speaks of South Africa as a society so deeply divided that it actually consists of two worlds. One world is modern, smart, professional, efficient and globally orientated, the other neglected, messy, unskilled, downtrodden and thriving on crime and violence; in fact South Africa has one of the greatest income disparities in the world.

Since the transition of the South African government, no miracle has happened and the high expectations that accompanied the historic election await fulfillment 11 years later. Millions still lack essentials, the country remains divided by race



and class, high unemployment, crime and violence still persist and poverty levels are extremely high. There exists a high correlation between poverty and the spread of HIV. Poor people have little access to health care and thus do not have access to condoms or treatments that would help to prevent the spread of the disease, such as the treatment of STIs (Panos, 1992:11). As Hunter and Williamson (1997:18) note: communities with the highest rates of infection rates are often the most impoverished and marginal because there are conditions conducive to rapid HIV transmission. Since poor people tend to have less access to television or radio their access to information about HIV/AIDS is likely to be limited. Poor people are also likely to be concerned about where their next meal is coming from than to worry about contracting a disease that will kill them in many years time. AIDS also exacerbates poverty (Evian, 1994:7).

People affected by HIV/AIDS are predominantly breadwinners of a family so as they become sick and lose their income, whole families fall into poverty. Within the context of a society struggling with issues related to violence, poverty, crime, poor housing, migrant labour, unemployment and malnutrition, South Africa is experiencing one of the fastest growing HIV/AIDS rate in the world.

These societal issues not only create conditions perfect for the HIV/AIDS pandemic to thrive, but also impacts on the ability of the system to cope with the additional burden of another crisis. South Africa has one of the highest rates of HIV/AIDS in the world with almost 5 million infections and is currently the greatest threat to reconstruction and development in South Africa.

### **Reasons for the rapid spread of HIV/AIDS in South Africa**

Due to the unique history of South Africa and its recent emergence from Apartheid, the country is faced with a variety of problems that have greatly exacerbated the magnitude of the AIDS epidemic. The residual effects of

apartheid still resonate today economically, infrastructurally, socioculturally and politically. Although the AIDS epidemic emerged later in South Africa compared to some other countries and the numbers of infection were low initially HIV/AIDS has surpassed other countries many fold. The reasons detailed have created the conditions, which have promoted the spread of HIV/AIDS in South Africa. The rapid spread of HIV/AIDS has enormous socioeconomic implications for the general population and South Africa as a whole. Some of the factors contributing to this are apartheid, poverty, rape, gender differentials, sexual behaviour, condom use, migrant labour, transport network, political turmoil and the government's policy and responses to the epidemic. These factors are discussed individually.

Under apartheid, the economy was dependant on foreign investment and technology. The government imposed inward-looking economic policies whereby white businesses were promoted and blacks were denied basic economic rights. According to the National Report on Social Development (1995), 61% of Africans are classified as poor compared to just 1% of whites. Under apartheid the black population also bore the brunt of discrimination, which created conditions ripe for the spread of HIV/AIDS. Apartheid policies severely disrupted traditional patterns of family life among black South Africans. Enforced removals, which split families and the migrant labour system, had a damaging effect on traditional sexual mores and the family structure. Traditional black communities have experienced a breakdown in social cohesion. This breakdown has contributed to the rapid spread of AIDS (Dirks, 1994:2).

Apartheid policies have had a detrimental effect on health provisions for the majority of the population. Discrimination in health care was institutionalised and still has repercussions today. Under the apartheid government, health care was decentralised to the provinces, which resulted in major under funding to the majority of the population and a major urban bias in health spending and provision. The inadequacies of the prevailing health structures have prevented

any possible implementation of an effective intervention to the AIDS crisis, even if they were either available or advocated.

Poverty is a major contributory factor to the transmission of HIV and the majority of black South Africans are poor. AIDS has been described primarily as an illness of marginalised persons, following the path of least resistance and affecting the poorest, most disadvantaged groups. The communities that are hardest hit are those that are already severely disadvantaged by having poor infrastructure and little or no access to basic services. Due to the high rate of black unemployment in some areas, for those families, surviving day to day is of primary importance. For this reason, the daily struggle of the African population with poverty, illness and violence has created an atmosphere in which the prevention of HIV, a virus that may not cause symptoms for months or years was and is a low priority to the African people. Although the present government has taken some measures to alleviate the problems there is still much to be done to alleviate poverty. While alleviating poverty will help to lessen the continuing spread of AIDS, it would take longer to see the effects by reduced poverty. The AIDS epidemic demanded and demands a more proactive response.

Poverty is related to overcrowding and is responsible for many of the social pressures that lead to high-risk behaviour. The forced removals described previously led to an overcrowding in the former homelands, with resulting poor living conditions (Department of Health, 1998). With the scrapping of the influx control laws there has been a steady trend towards urbanisation among the black population. The majority of these migrants have settled in large informal settlements on the peripheries of major cities.

Little investigation has been conducted locally into the urban and rural levels of HIV prevalence. Early figures from the Johannesburg City Health Department suggest an urban prevalence is roughly 2.7 times higher than the rural prevalence (Webb, 1994). The fact that prevalence in the rural areas is low may

seem surprising, given that levels of income and levels of knowledge regarding HIV/AIDS are lower in these regions. Furthermore, levels of prevalence of other sexually transmitted infections are higher in rural areas than urban areas. This differential also may be due to temporal factors. In many sub-Saharan countries the AIDS epidemic has been slow to spread to rural communities because of their relative immobility and geographic isolation. Once the epidemic is imposed into the rural community, the incidence pattern may follow that of urban areas. As the epidemic spreads and as prevalence levels in urban areas begin to level off, the difference between urban and rural prevalence levels is likely to diminish.

Rural communities in South Africa are not as static or geographically isolated as those in the rest of Africa. The migrant labour system has caused a steady flow of HIV-infected men into and out of the rural communities, in which their wives and families are situated, and the urban areas in which they work. The superior transport system in South Africa may have also ensured a more rapid spread of the epidemic to rural areas thus the differential is small in South Africa.

Since the change in South Africa's political dispensation in 1994, much political emphasis has been placed on the rights of women and the need for gender equality. However, South Africa remains a fairly patriarchal society, in which women are vulnerable to sexual abuse. In 1998, South Africa had the highest per capita rate of reported rape in the world (115.6 for every 100 000 of the population), based on the common, but highly debated, assumption that only one in every twenty rape cases is reported. According to Rape Crisis Cape Town, close to 1 million acts of rape occur in South Africa every year. Marital rape is under-reported, with many relationships being characterised by violence and sexual abuse.

Vundule et al (2001) found, in a study of black teenagers attending antenatal clinics in Cape Town, that 72% of girls reported having been forced to have sex at some stage and 11% reported having being raped. The South African National Survey (Kaiser Family Foundation, 2001) also found that 39% of sexually

experienced girls had been forced to have sex. In many cases women have limited control over their sexual activity and are thus more vulnerable to HIV infection. In 2002, according to South African Police Services, 21,000 child rapes were reported which also included infant rapes. According to Dr. Pitcher from the University of Witwatersrand, "Child rape of children over five years occurs all over the world but the rape of infant girls only occurs here". The reasons postulated were that South Africa is strife-torn with major socio-economic problems as well as the myth that sex with virgins can rid men of HIV/AIDS and other sexually transmitted diseases (Sunday Tribune, 28/11/2004:pg 18).

A Unilever study (2004) stated that South African men do feel stressed by the rapid social changes taking place around them. It has been argued that the HIV/AIDS pandemic as a whole is closely connected to the historical disempowerment of men. The colonial onslaught that resulted in the progressive demise of the traditional roles and statuses, the loss of opportunities for expressing culturally appropriate forms of manliness, social dislocation and increasing poverty have all been significant when trying to understand some of the structural and behavioural factors that have driven the spread of HIV/AIDS. Perhaps what has exacerbated the situation in South Africa has been the twinning of the promise of a better future, with the demise of apartheid, and the spectre of no future with the advent of the AIDS pandemic. It has been said that the AIDS pandemic would magnify all existing social problems and it has. Just as HIV/AIDS has fuelled our rape crisis, the rape crisis has fuelled our HIV/AIDS crisis (Madladla, 2004).

Alarming figures show a dramatic increase in HIV in 2003. Young women between the ages of 18 and 30 are becoming infected at a higher rate than the most 'at risk' groups in the world. Seven out of every 100 women (in Durban) become infected during one year. This might be only the 'tip of the iceberg' as there are many more women who are unwilling to be tested and are unaware of their status (Ramjee, 2004).

The Medical Research Council (2004) also stated that the prevalence rate i.e. the infection rate at any one time among women in KwaZulu-Natal is between 37% and 47%. In their study, none of the women were pregnant and most were married in stable relationships. Couples now face the choice between contracting HIV and having a child, as barrier methods would not be the choice if a woman wanted to conceive. The significance of patrilineal descent and of lineage membership among South Africa's people rate the procreation of children highly. Being able to bear a child is an essential part of being a woman and achieving success as a woman. Both women and men generally accept the traditional view of male supremacy, male sexual prowess and female submission and availability. The history and continuation of patriarchal gender inequality have caused the African woman to be unable to exert control over their own bodies both because of their race and their gender. Women in poor socio-economic circumstances are particularly at risk due to their relative lack of power and access to resources and information. It also prevents them being able to negotiate safe sex (Siedel, 1996).

Microbicides, which are vaginal, gel or foam-like substances that can be used by women to lower the risk of infection as cited at the World AIDS Conference in Bangkok in 2004 needed to be fast-forwarded rapidly. In the absence of an AIDS vaccine, which researchers admit is now at least 15 to 20 years away, microbicides were seen as one of the only viable short-term preventive measures on the horizon. The microbicide research programme conducted by the South African Medical Council will continue until 2008.

As African societies within South Africa struggle to adapt to their changing environment, sexual relationships are also changing. While notions about masculinity and fertility vary widely among South Africa's diverse ethnic groups, health workers agree that traditional culture has strict rules governing sexual relationships. These codes have broken down and nothing has replaced them. Forms of behaviour that increase the risk of HIV infection are engaging in unprotected sex with one or more partners or with risky sex partners. A lack of

HIV/AIDS related knowledge such as modes of transmission and proper condom use, misconceptions, faulty beliefs and attitudes and peer pressure are other factors that increase the risk of contracting HIV. According to a national survey, half of the respondents reported that they had not used condoms in their last sexual encounter, with young people and women reporting higher levels of failure to use condoms (Patel, 2004).

The use of condoms can reduce the rapid spread of HIV/AIDS. However, in South Africa, the use of condoms has a severe social stigma attached to it. Historically, the African people viewed the promotion of condom use as a population control strategy used by the Afrikaner government to weaken the African population politically. There is doubt as to whether the present government has the ability to convince the majority of black South Africans to change their sexual behaviour. Very few people in the rural area see the lack of condom use as a determinant factor in the contraction of STIs and AIDS and the contraction of AIDS is often seen in the light of promiscuous behaviour. There exists a general perception by both men and women that condom use is 'unnatural' and a 'waste of sperm' and therefore undesirable (Houle, 2003). The use of condoms is rejected out of a sense of both men and women's gender identities that are embedded in aspects of fertility. Religion and sometimes the church's refusal to support condoms also play a strong role. Beyond the stigmas attached to condom use, there does appear to be an increase in their use. However, those who want to use them are often hampered by the attitudes of their sexual partners. Condom use by sex workers results in a loss of clients, frequent non-payment and physical abuse. Condom use is also problematic for married women.

The development of 'African homelands' and the corresponding concept of racial segregation set in motion a migrant labour system that has contributed to the rapid spread of AIDS. Movement of people from one area of the continent to another has been a major factor in the spread of the HIV virus (Schoepf, 1993).

These men were separated from their wives and families during their labour contract of nine to eleven months and during a sexually active period of their lives, thereby setting up a market for prostitution and unstable behaviour. At the other end of the spectrum, women left behind by their migrant husbands become defacto heads of households. This exposes them to emotional, psychological, financial and material hardships. To obtain the basic necessities of life for themselves and their families these women or daughters are often forced into prostitution (Niftriak, 1994).

Closely related to migrant labour is the issue of the role of transport networks in providing railways for the spread of HIV/AIDS. There are high infection rates associated with main roads and transport routes. The influence of truck drivers on the spread of HIV/AIDS is also critical in South Africa. The extreme mobility of the migrant labour system and transport routes have provided an avenue for the rapid spread of HIV/AIDS.

The 1980s and 1990s, have seen HIV/AIDS spread throughout the African continent whereby South Africa has been badly affected by violence, political and social instability and economic decline. Disruption on such a scale affects attitudes towards risk. Taking alcohol, drugs and sex can be seen as an escape from a difficult existence (Panos, 1992:13).

While South Africa is the best-equipped African country to respond to the AIDS crisis and has the strongest economy and infrastructure, its response has been slow and complacent. Warnings of an impending catastrophe went unheeded in the early 1990s, when there was still time to avert the worst. In the context of apartheid until 1994, the apartheid regime ignored signs of an impending epidemic and did little to educate the public.

This official denial of the dangers of AIDS was fuelled by prejudice towards gays and black people in general. The South African government's response to AIDS



first came to the fore at the end of 1987 when it was announced that 1000 infected migrant labourers would be deported and that compulsory AIDS testing would be given to all black immigrant workers before being given contracts. However, there was no other concerted action. Through the transition to a democratic government the issue of AIDS got lost and put on the back burner. Although AIDS was deemed to be South Africa's biggest threat the government was silent on the issue. The government later explained its initial laxness on policy as being due to the relative unclarity about the disease and because AIDS was related to the sexuality of people it was a taboo subject for political parties to address. As the government's response was minimal the disease was allowed to spread unhampered.

The Premiers' HIV/AIDS Indaba has signaled that the people of KwaZulu-Natal has risen to the occasion of facing the challenge of HIV/AIDS according to the government as cited in the Sunday Tribune dated 4 March 2004. In light of the ever-increasing nature of the epidemic this is debatable. The Health, Economics and HIV/AIDS Research Division of KwaZulu Natal (HEARD) (2004) maintain that since the cabinet's approval of the governments operational plan for comprehensive HIV and AIDS care in November 2003, minimal development has taken place countrywide to implement the programme and many provincial departments were unable to provide concrete information on their roll outs. Historically, South Africa has had a turbulent past, and this history is relevant to the explosive spread of HIV in the region. The history of the management of the AIDS epidemic to some extent explains the high level of prevalence in the country.

When the first democratic government came to power in 1994, its primary concern was to ensure transformation and AIDS was only one item on a long list of challenges. In the last decade the government has been involved in a number of scandals and controversies over its handling of the AIDS crisis such as the Sarafina scandal of 1995 whereby there were irregularities surrounding the

musical stage production and later, the declaration that AZT a licensed drug was dangerous to prescribe for pregnant and HIV women. However, most controversial of all, has been President's Thabo Mbeki's questioning of the widely held view that HIV caused AIDS and the denial of the links between AIDS and HIV (Guest, 2001).

The extremely high prevalence figures showed that there was clearly an explosion in HIV prevalence between 1993 and 2000. This was the time the country was distracted by the major political changes through which it was going, and during which it is possible that the severity of the epidemic might have been lessened by prompt action. While the attention of the South African people and the world's media was focused on the political and social changes occurring in South Africa, HIV was silently gaining a foothold and the spread of the virus did not get the attention it deserved. There developed a perception that the government was doing nothing about the epidemic.

At the International AIDS Conference in Bangkok in 2003, delegates denounced the South African government's policy on this great catastrophe. According to the Sunday Tribune (08/08/2004), the South African government was referred to being laxisidasical in terms of its implementation policies on AIDS. At the first South African AIDS conference hosted in Durban in August 2003, the passionate pleas of people infected with HIV, continued to weigh public opinion against government policies. This pressure was exacerbated by the effective legal challenges against the government's apparent unwillingness to implement policy on AIDS and the threat of further legal action around the delivery of ARTs if the new plan was not implemented. This pressure was complemented by ongoing international forces, ranging from calls for the South African government to express political commitment to fighting the epidemic to developments such as access to treatment drugs at the World Trade Organizations meeting in September 2003.

Since 1994, the response to the socio-economic challenges facing South Africa has been characterised by massive policy and legislative reform. Much of what already needs to be done is already in place in policy. The challenge lies in implementing these policies and strategies and in monitoring and evaluating their appropriateness and effectiveness in the context of the HIV/AIDS pandemic.

### **Uganda's Response to the Pandemic**

Many countries in Sub-Saharan Africa are facing the rapid spread of AIDS. Yet few governments have paid more than lip service to the problem. The exception is Uganda. Although the country is poor, the Ugandan government is open and has shown an impressive commitment to fighting the disease. President Yoweri Museveni was outspoken about AIDS despite sex being regarded as taboo in most African countries. Uganda has also been revolutionary in its initiatives on children orphaned on account of AIDS. Initiatives have proceeded through the combined efforts of NGOs, local communities and the government.

South Africa could learn from Uganda and its inventive policies. By taking AIDS seriously and making it a national priority, Uganda has managed to lessen the impact of the crisis. South Africa already has advantages over Uganda in terms of money, infrastructure, better health services and communication networks. Uganda's example could be inspirational in terms of its commitment to open dialogue on the subject of AIDS and its multi-faceted approach. South Africa needs a similar approach that is aggressive and will address the issues of sexual behaviour, orphans and gender inequality with openness and inventiveness. South Africa has the potential to make great strides in controlling the epidemic. There is much that can be done now to keep the epidemic from getting worse and to mitigate the negative effects. However, this requires a grand national effort on all levels. A strong political commitment to fight against AIDS is critical as is evident in countries such as Uganda, Thailand and Senegal, which have all

shown strong support from top political leaders. As South Africa is one of the leaders on this continent a breakthrough in the country will spark a similar response and commitment from neighbouring countries and resources will flow to sustain whatever South Africa decides to undertake. It is believed that the world, overwhelmingly, wants South Africa to defeat the pandemic (Whiteside 2002).

### **The traditional African Worldview**

If education and prevention programmes are to be successful in Africa, it is important to understand and appreciate the traditional African 'worldview.' The majority of the people of Africa experience the world in a unique and specific way that is different from the way in which the westerners experience the world. This unique African worldview has for too long been ignored by the Western world. HIV/AIDS education and prevention programmes have mostly been based on Western principles and no attempt has been made to understand or integrate the diverse cultural and belief systems of Africa into such programmes. One may ask if this is not one of the reasons why HIV/AIDS prevention programmes have tended to fail so dismally in Africa. It is important for professionals to understand the meaning of health, sickness and sexuality in the traditional African context and to incorporate the beliefs into their HIV/AIDS prevention programmes (Wyk, 2001).

### **Socioeconomic impacts of HIV/AIDS In South Africa**

The epidemic has already reached catastrophic proportions in many parts of the country and it is expected that prevalence levels will continue to rise for years to come. This has a strong impact on females, demographics, the educational and health sector, and majority of South Africans who are poverty-stricken,

households, business and economics and importantly on various aspects related to children. The impact is explored in further detail.

The epidemic's impact is particularly hard on women and girls as the burden of care usually falls on them. Girls drop out of schools to care for sick parents or younger siblings. Older women often take on the burden of caring for young adult children and later, when they die, adopt the parental role for the orphaned children. They are often also responsible for producing an income. Older women caring for orphans and sick children may be isolated socially because of the stigma surrounding AIDS and discrimination.

Unequal gender relations and social, economic and cultural factors are directly connected to the high infection rates among women (Malberbe 2002:339). For instance some women have been hesitant to seek HIV testing or have failed to return for their results because they fear that disclosure of their HIV positive status may result in physical violence, expulsion from their home or social ostracism (UNAIDS 2004:40).

Interventions are needed that empower women to make decisions related to their sexuality and to ensure that women's access to HIV prevention, AIDS care and related services include sexual and reproductive health. Strategies should involve men in promoting women's empowerment.

People living with AIDS experience discrimination at the individual, institutional and societal levels. Stigmatisation of and discrimination against people with HIV/AIDS are prevalent in South African society. AIDS related stigma and discrimination could lead to social isolation of people who are infected. These attitudes hamper progress in treatment and care and in preventing the spread of the disease. It is important for practioners to recognize gender and other forms of discrimination and to understand the consequences of those affected (Patel, 2005).

Domestic violence is common among HIV infected families and has become one of the major stumbling blocks to disclosure among married woman in South Africa. The fear of disclosure makes it difficult for women to make informed decisions on choices such as breastfeeding, family planning and planning for the future of her existing children without raising suspicion about her HIV status.

Stigma also means that family support is not a certainty when women become HIV positive. They are often rejected and may have their property seized when their husband dies. There is a tendency to depend heavily on women's work of caring for the children, the sick and other members of the household, a role that has been loaded with more responsibility as more women have been drawn into productive work in the economy. With the numbers of orphaned and vulnerable children increasing due to the HIV/AIDS pandemic, the burden of care has fallen heavily on women as community and home-based carers and kinship groups that are already strained (Patel, 2005:139).

The human toll and suffering due to HIV/AIDS is already enormous. HIV/AIDS is by far the leading cause of death in Africa. Demographic changes will lead to a doubling of the ageing population over the next two decades and the impact of the HIV/AIDS pandemic is expected to have grave consequences for future generations (Patel, 2005).

Globally, AIDS is a significant obstacle to children achieving universal access to primary education by 2015. An estimated one billion dollars per year is the net additional cost to offset the results of AIDS. The epidemic is expected to significantly contribute to future shortages of primary school teachers. Without forward planning, there will be great difficulty in meeting school enrolment and targets and an acceptable pupil-to-teacher ratio. As skilled teachers will fall sick and die, the quality of education especially in rural areas suffers. Children, especially girls from AIDS affected families, are often withdrawn from schools to compensate for loss of income through a parent's sickness and related

expenses, to care for sick relatives and look after the home. The families may also take their children out of school, as they cannot afford to keep the child at school. The South African government has prioritised policies and programmes regarding HIV/AIDS at school as many studies have shown that young people are prone to risk-taking behaviour in their teenage years regarding sexual behaviour. In addition, the proportion of teenagers are having sex at a younger age. A survey of six provinces in South Africa revealed that 10 per cent of the respondents had sex by the age of 11 or younger. In KwaZulu-Natal, 76 percent of the girls and 90 percent of the boys were found to be sexually active at the age of 16 (Sewpaul and Raniga, 2005), cited in Adams et al (2005).

The epidemic has created a need for robust, flexible health systems at a time when many affected countries such as South Africa have been reducing public service spending to repay debt and conform to international finance institution requirements. So already weakened systems are being forced to cope with the extra burden of sickness and the loss of essential staff through sickness and death related to AIDS.

In South Africa, the living standards of many poor people were already deteriorating before they experienced the full impact of the epidemic. In general, AIDS affected households are more likely to suffer severe poverty than non-affected households. It has been recognised that South Africa is in a classical poverty trap whereby mass poverty and unusually great inequalities in themselves prevent rapid growth and development. On the one hand, mass poverty limits domestic demand and economic growth and on the other it prevents the majority from getting the skills and assets they need to be economically productive. In the past decade, the rapid rise in unemployment, now running close to 30% has aggravated the problem. Government intervention is critical to break the vicious cycle of poverty.

The toll of HIV/AIDS on households can be very severe. Although no part of the

population is unaffected by HIV, it is often the poorest that are the most vulnerable to HIV/AIDS and where the consequences are most severe. In many cases, the presence of AIDS means that the household will dissolve as parents die and children are sent to relatives for care and upbringing. But much happens to a family before this dissolution happens. HIV/AIDS strips the family of assets and income earners further impoverishing the poor. Taking care of a person sick with AIDS is not only an emotional strain for household members but also a major strain on household resources. Loss of income, additional care-related expenses, reduced ability of caregivers to work, the mounting medical fees and funeral expenses together push affected households deeper into poverty (Gow and Desmond cited in Whiteside (2002).

According to Patel (2005) many South African companies have introduced policies and programmes on HIV/AIDS in order to curtail the spread of the disease. South Africa's economic fate in the 21<sup>st</sup> century depends on the willingness of corporations to implement proactive and compassionate HIV/AIDS workplace policies and programmes. Some companies have signed agreements with trade unions to provide anti-retroviral treatment and the co-funding of medication to boost the immune system of employees. Companies have adopted anti-discriminatory policies and they are also responding to the call for anti-retroviral medicines at preferential pricing to governments, NGOs and international groups.

HIV/AIDS also has serious economic implications. The two major economic effects are a reduction in the labour supply and increased costs. As those most stricken with AIDS are generally from the most productive age group in society, there is concern about how the AIDS epidemic will affect productivity, income and overall economic development. A considerable percentage of the workforce and decision-makers will be affected by the AIDS epidemic. About half of HIV infections are occurring before the age of 25 and those men and women are typically dying by 35 years of age. AIDS is killing people in their most



economically productive years. Sickness will affect productivity in the workplace and the competitiveness of the country's economy. As the skilled and unskilled labour force is depleted, economic growth is potentially reduced by 2.5% each year. Productivity and profitability are directly and negatively impacted by absenteeism due to sickness and funerals, an increase in accidents, loss of skills and labour due to sickness, death and emigration, decrease in employee morale and increased costs (Knight, 2004).

The consequences for business and the economy concerning HIV/AIDS include uncertainty among international investors, lower levels of fixed foreign investment, labour disputes, unstable quality, decline in tourism and increasing government debt. There is evidence, as presented by the World Bank and UNAIDS (2004) that national wealth in South Africa will be reduced by 15-20% over the next 10 years as a result of HIV/AIDS.

Lower economic growth and increased poverty threaten to form a vicious cycle, in which AIDS drives many families into deepening poverty and at the same time poverty accelerates the spread of HIV. The individual and their families will be greatly affected economically. Increasing discrimination in the workplace will result in HIV positive workers losing their jobs. The burden on families who have to care for and bury people dying of AIDS, and those who lose breadwinners will be enormous. The socio-economic impact of AIDS has far reaching consequences to the extent that through selectively killing people in the most productive age groups, the pandemic is creating two highly vulnerable groups of survivors i.e. the elderly and the young orphans who have lost their primary sense of support.

While HIV/AIDS will pose significant economic costs over time, the macro-economic impact is likely to be linked to a Gross Domestic Product (GDP) growth rate reduction of about 1% per annum. However, as the epidemic is expected to peak around 2010 and the economic effects of this will not be felt until twenty or

thirty years later, it is extremely possible that AIDS will seriously impede macro-economic growth. While AIDS economic costs are deemed sustainable for the next ten or fifteen years by economics, its implications are substantial and will expand with the epidemic (Knight, 2004).

### **Impacts on Children**

Currently there are an estimated 660 000 orphans as a result of HIV/AIDS in South Africa. (UNAIDS, 2004). By 2015, there will be almost 2 million orphans, an increase of over 600%. This is clearly a catastrophe of considerable magnitude. These children growing up without parental guidance will for the most part be unloved, uncared for, unsocialised and uneducated and the impact on the children is devastating. The psychological, developmental and economic impact is discussed.

It is hard to overemphasise the trauma and hardship that children affected by HIV/AIDS are forced to bear worldwide. Not only does HIV/AIDS mean that children lose their parents or guardians but sometimes it means that they lose their childhood as well.

The psychological impact and emotional well being on the child or children witnessing the suffering and death of a parent is extreme. There are also severe psychological health impacts for children and indirect impacts from being cared for by someone who is exhausted, distressed and desperately poor. For many children this is exacerbated by the fear and insecurity of not knowing who will care for and support them after their parent's death. The orphans face the additional burden of not being able to grieve openly for a deceased loved one because of the stigma associated with an AIDS related death. The long term effects of this is likely to plague South Africa for many years to come, with

desperate disillusioned youth turning to anti-social and risk taking behaviour and crime (Foster, 1997 and UNICEF, 1991).

Abandonment may happen on two levels. The first is the abandonment of the family by a caregiver or breadwinner. It is commonplace to hear of women whose partners or husbands abandoned them when they disclosed their status to their partner. The second is the abandonment of the child. There has been an increase of 67% in the numbers of abandoned children in South Africa. (National Council for Child Welfare, 2002). As the children affected and infected by HIV is a crisis in its own right, the impact of HIV on the health and welfare services for children is multi-faceted. While the pandemic results in increased demand for services, it reduces the capacity of the system to provide services. The impact of orphans on the welfare sector in South Africa is discussed in Chapter 3.

One of the consequences of HIV is poor health and increased rates of stunting among children due to a lack of adequate nutrition. In addition, increased exposure to opportunistic infections, disease related poverty and psychosocial factors impact on caregiving practices and child well being. With caregivers being sporadically sick or absent, the child is less likely to get the medical attention he or she needs and more likely to have repeat infections. Food security is affected by reduced household income. Preparation of food is also affected by compromised care giving. The child may also not be able to eat due to a range of physical, emotional and psychosocial factors, which play a role in appetite suppression. Prior to the emergence of HIV, large numbers of children and families already lived in poverty. The epidemic is worsening and deepening poverty experienced by the poorest children and families. An area of concern is the issue of children as caregivers. Many children are taking physical care of their ill HIV/AIDS infected parents or relatives. Some organizations have responded to this by providing training to such children on how to avoid getting infected e.g. providing gloves etc. However, many activists are of the view that this may appear to be an accommodating situation rather than addressing the

problem. A fundamental issue to be addressed is the question of why children have to take on these responsibilities, which are beyond their capacity and in fact may be harmful to their development (Gow and Desmond, 2002).

In households caring for children orphaned or abandoned as a result of HIV/AIDS, human and material resources are stretched. The increase in dependants within the household reduces the quality of care offered to children of those families. By 2011, 56% of the population will live in households where at least one person is infected or has died from AIDS (Gow and Desmond, 2002).

At the household level, the impact of HIV/AIDS on children is exacerbated by the fact that HIV usually strikes more than one member of an infected household and this usually includes the primary caregiver or breadwinner. When a family member has AIDS, the average household income may fall drastically while expenditure quadruples with the costs of special medical treatment, transport to health facilities, nutritional requirements and ultimately funeral costs. The financial impact of an AIDS related death on the average family is far greater than the financial impact of any other cause of death (Bureau for Economic Research, 2002).

The financial burden of HIV/AIDS adversely affects the living standards and quality of life of all household members, leading to food insecurity, malnutrition, poor hygiene, loss of opportunity and other factors related to poverty. With competing priorities for limited resources, children in infected household are unable to afford school uniforms, school fees and books, which are a prerequisite for school attendance. The combined consequences of HIV/AIDS on children in infected households is far reaching, with reduced opportunity for growth and development creating a cycle of dependency, vulnerability and abuse (UNICEF, 1991).

## **Conclusion**

South Africa's historical and apartheid legacy has left the country with all the ingredients to ensure that it would have the most explosive and extensive epidemic in the world. The HIV/AIDS epidemic in South Africa shows no signs of halting. KwaZulu-Natal has been rated as having the fourth highest prevalence in the country and these figures continue to rise. In the next few years the numbers of adults and children infected and affected by HIV/AIDS will place tremendous strains on traditional methods of childcare. This will have a devastating impact on child welfare organisations that are already over-stretched and under-resourced. The challenge of HIV/AIDS and its impact on child welfare organisations in KwaZulu-Natal are discussed in Chapter Three.

## **Chapter Three**

### **CHILD WELFARE ORGANISATIONS NATURE AND FUNCTIONING**

#### **Introduction**

In the next few years the escalating numbers of children and adults affected and infected by HIV/AIDS in KwaZulu-Natal will have enormous implications on extended families and child welfare organisations. One of the greatest challenges facing child welfare organisations is the task of developing appropriate and affordable services and support systems for families and children infected and affected by HIV/AIDS as the epidemic will severely test the potential of child welfare organisations which are already overburdened, overstretched and under-resourced.

This chapter discusses social services and Chapter Three examines social security. The historical development of welfare and its impact in the South African context will be initially discussed. The chapter then discusses international and local trends in welfare and incorporates the important policies and their implications for child welfare organisations in South Africa. The latter part explores various existing and alternate models of care and concludes with some alternate perspectives to social work.

#### **History and origin of Welfare**

In essence, 'welfare' means the well being of individuals and the satisfaction of an individual's needs (George and Page, 1995:1). Human needs can be defined

in restrictive terms, relating to minimal material needs that will ensure an individual's survival, such as food, shelter and clothing. Alternatively, a more comprehensive definition can be utilised to include a comprehensive range of social and cultural needs (Dube, 1988: 55).

From the earliest centuries, individuals with the support of their families were in general responsible for their own welfare. The idea that welfare should be the responsibility of the state emerged in Europe between 1880 and the early 1940s. The economic theories of John Maynard Keynes and Beveridge were widely accepted and provided justification for the intervention of the state in the economy and society (George and Page, 1995:1).

The Keynes-Beveridge approach was based on the idea of 'correcting' the tendencies of the market economy through state intervention in social policy (Luiz, 1994). A major assumption was that individuals with higher incomes or better opportunities had an obligation to assist those who were less fortunate and wealth would be achieved via taxation. These ideas had an important influence on social policy in many countries including South Africa whereby a much-diluted version of the Beveridge model of welfare was gradually introduced for the benefit of the white population. Many of the assumptions about nuclear families contained in the Beveridge report were also incorporated into the South African welfare system.

A few writers have analysed the effect of Beveridge on welfare policies in South Africa. Lund (1997) and Richter (1994), amongst other writers, pointed out the inappropriateness of basing welfare policy on the nuclear family in a country in which there are a number of forms of marriage, where many people live in three generational households, where as a result of apartheid families have been separated due to migrant labour and influx control policies, where a large number of rural women live in women headed households and where a significant proportion of children are raised separately from one or both partners.

Hayek (1994), an influential theorist of the New Right, challenged the principles of the welfare state since the 1940s, but it was only in the 1980s that his ideas gained prominence. Hayek argued that societies are made up of individuals who function independently of each other and that the maintenance of the market system is the prime condition of the general welfare of its members (Hayek, cited in George and Wilding (1994). The Thatcher government in Britain in 1979 and President Reagan in the USA in 1981 implemented the neoliberal agenda. The resurgence of free market ideas and reduced government involvement in social welfare is strongly associated with neoliberal thinking. Conservatives argued for limited government intervention in human affairs, free markets, economic liberalisation and privatisation, individual responsibility for well-being and the creation of mediating structures between those in need and governments to address social problems and to diffuse conflict between them (Patel, 2005:25). Culpitt (1992) argued that the debate about welfare became dominated by the 'logic' of economic rationality rather than the ideas of 'social obligations.'

Although the welfare state has not been totally abolished, it has been radically altered in many countries. The view that markets should play the major role in the provision of social services means that reduction in public expenditure, contracting out of state welfare services and creating for profit social services became key elements of welfare policy. The reasons why these ideas became so influential internationally, must be viewed in the context of the prevailing economic climate of the 1970s and early 1980s. During this period, an economic recession, declining international growth rates, and oil price rises, meant that public expenditure was increasingly financed through public borrowing (George and Page, 1995). Moreover, increased globalisation of economies reduced the power of national governments to influence events (Madley and Clough, 1996:14).

The global dominance of free-market ideas affected developing as well as developed countries. Many developing countries had borrowed heavily in the



1970s when interest rates were low. They were then forced to cut back on social welfare programmes as interest rates soared and were faced with a huge burden of debt. Many of these countries were forced to borrow from the International Monetary Fund and the World Bank, which imposed severe conditions compelling countries to make substantially, reduced state welfare provisions (Midgley, 1995:65).

It was believed that the welfare state is a threat to individual liberty because individuals cease to be free to make choices about and take responsibility for their own welfare. According to this belief, individuals should rather operate as if in a market place, making individual decisions about what will best meet their needs, with no faith in ideas of 'the common good' (Culpitt, 1992:1). Critics associated with feminist, neo-marxist, post-modern and anti-discriminatory perspectives to social welfare and policy noted that capitalist change serves the interests of the oppressive class (Patel, 2005:26).

Paradoxically, the desire for 'economic rationality' and public expenditure cuts led to the call from many governments for a growth in 'community care' which both relies on the notion of social obligation and restricts choices for individuals, in particular for women.

Etzioni (1996) stated that he does not oppose the ideas of the 'welfare state', but believes that the welfare state has exhausted its capacity to continue to provide an ever-expanding number of functions and its ability to raise taxes to pay for them. Accordingly, the answer lies in calling on individuals and communities to fill the gaps between needs and services.

### **The origins and development of South African Social Welfare**

The ideas of racial discrimination, the denigration of indigenous ways, paternalism in social services and the distorted nature of social welfare policies favouring whites influenced South African welfare policies up until 1994 (Patel, 2005).

The South African Welfare system was founded on the principles of racial division, a rejection of socialism, partnership between the state and community and a movement from residential to community based services. The introduction of the state into welfare provision in South Africa during the 1930s was not due to any shift in these underlying philosophies, but rather to political pragmatism, the need to maintain a high standard of living for the white population and thereby ensure political stability (McKendrick, 1990).

### **Apartheid and Welfare Policy**

The period after the Second World War saw the rise of the welfare state in many countries. It was accepted that the state should be the main provider of welfare services, either directly through the provision of services or indirectly through the maintenance of employment. In South Africa, however, a different ideology was implemented at the time. The election of the national party in 1948 marked the beginning of apartheid and of separate development of the races in all aspects of life, including welfare. Between the 1950s and the early 1990s 'race' became the primary factor in the allocation of resources (McKendrick, 1990). During this period, the South African government adhered to the philosophy of free market capitalism and a rejection of the welfare state.

While it was accepted that families should provide for their own needs and that state services should only provide in extreme circumstances, the South African

government's policy continued to ensure the welfare of the white population. In order to further its racist goals the government intervened in the workings of the 'free-market' in order to provide support to the white population through such means as job and land reservation policies and housing subsidies (Sunde and Bozalek, 1995:67).

Apartheid policies eventually led to a costly, inefficient and fragmented welfare sector e.g. welfare expenditure was extremely high, given the small white population and their high standard of living to the neglect of black welfare needs (Patel, 2005:71). Indians and coloureds eventually were incorporated into the provisions of welfare in terms of different departments rendering services to a particular race group but on a lower scale than the whites. No department was separately constructed to cater for the needs of the black population.

### **Developmental Social Welfare**

South Africa is one of the few countries that have adopted a developmental approach to social welfare in line with the United Nations World Declaration on Social Development (Department of Welfare, 1997:71). Social development has been defined as "a means of promoting an individual's welfare by purposefully harmonising social policies with measures designed to promote economic development" (Midgeley, 1995:159).

Developmental social welfare is a wide concept, which encompasses a range of other concepts and strategies. These include community development, community based programmes, community action, developmental social work, community work, community organisation and community care. Many of these approaches overlap and the boundaries between concepts are frequently blurred. This has led to a debate about the need to clarify the meaning of terms.

In the 1960s and the 1970s the idea of community development flourished. It was promoted by the UN as an important strategy in developing countries. The UN (1963) referred to community development as a process by which the state working in partnership with local people wants to improve economic, social and cultural conditions of communities and to enable them to contribute to national progress. However, in many countries a significant proportion of community development programmes have been undertaken not by the state but by non-governmental organisations. This is especially true of South Africa, where civil society organisations promoting community development proliferated under apartheid. Community development also stresses the importance of sustainability in development and the realisation that unless people are fully involved in the process of development any change is likely to be short-lived. Louw (1993) stated that if community development is to be successful, identification of need at the community level and active involvement of members of that community is necessary. Criticism of community development as defined by the UN grew during the 1970s as development programs failed to deliver the promised benefits.

In response to this, a more radical concept, 'community action' was developed. Rather than relying on government or outside agencies the community action approach empowers people to become politicised to take control of their own development initiatives (Midgley, 1995).

Historically, the funding of welfare services in South Africa has been geared towards institutional rather than community care (Department of Social Welfare and Population Development, 1995). If the community predominantly conceives of community care as care, then it has to be provided by the individuals within that community. "In practice, community care is overwhelmingly care by kin, especially female kin, not the community" (Walker, cited in Snaith 1993:53). Feminist analysis argue that the ideology and practice of community care reinforces gender divisions and have been based on 'Familism' which is based

on the ideology that the nuclear family is the norm and the natural place for the woman is in the domestic sphere. Thus these policies ensure that women are trapped in the traditional caring roles (Dominelli, 1991).

The recognition that the private and personal sphere of life is also political is a central idea of radical feminist analysis. If women are to have choices and are to be able to gain independence through employment, then caring must be seen as more than simply a private and personal matter. Women are more likely than men to be under pressure to take on caring roles, and if necessary to give up employment, not just because of patriarchal ideas that caring is 'women's work' but also because of their disadvantaged position via the labour market where they are typically in part-time, low paid and low status employment (Tester, 1996).

In countries, which have adopted community care policies, women are increasingly expected to take on responsibility not only for their children, but also for other vulnerable and dependant kin. Such policies are attractive to politicians because they control the costs of care borne by the state, however, they do not take into account the costs for women in terms of income lost.

Although the full impact of HIV/AIDS has yet to be felt, the epidemic has already brought about a growth in the number of 'home-based care schemes', which depend on the care of the sick by their relatives, usually female. The ideas revolving on what constitutes the family have historically underpinned welfare policy in South Africa and definitions based on stereotypical view of the nuclear family as the norm have been enshrined in laws relating to areas such as marriage, divorce, illegitimacy and adoption (Segar and White, 1992). In South Africa, gender, race, class, language, age and ethnic power relations have mediated the experience of families. It is important to take cognisance of the political and historical significance of family life in South Africa, and to acknowledge and recognise the nature of different types of family structures in

this country. It must be realised that the existence of large numbers, single parent families, extended families and other types of families do not fit into the nuclear family norm. (Segar and White, 1992). While community care can give individuals a better quality of life than they would have in an institution, it can equally be a convenient cover for neglect by the state.

### **A changing welfare policy in South Africa**

In the run up to the first democratic elections in 1994, the future of a welfare policy in the 'new' South Africa became the subject of intense debate as the social welfare implemented by the National Party was characterised by being located in urban areas, focused on institutional care, racial and oppressive policies in favour of the white population and incapable of meeting the needs of the majority who were impoverished. These deliberations culminated in February 1997 in the publication of the 'White Paper for Social Welfare', which was closely linked to ideas for the broader transformation of South Africa in the post apartheid era. The White Paper for Social Welfare places emphasis on the critical importance of reorientating the South African Welfare system to one based on the principles of 'developmental social welfare.'

### **The White Paper for Social Welfare**

The White Paper for Social welfare recognised the need for radical change. It calls on South Africans to participate in the development of an equitable, people centered, democratic and appropriate social welfare system. The mission is to serve and build a self-reliant nation in partnership with all stakeholders through an integrated social welfare system which maximises its existing potential and which is equitable, sustainable, people centered and developmental. (Department of Welfare, 1997:5).

Several key ideas contained in these statements include: Firstly, there is an emphasis on the promotion of services, which are community based and developmental. Sustainable services should be developed which 'build human capacity' and foster 'self-reliance'. Individuals and communities are not to be passive recipients of welfare, but rather will play an active role in the promotion of their well being.

Secondly, there is a move towards a more 'accessible' and 'appropriate' welfare system. Rather than maintaining an over reliance on approaches based on western theory and practice, new approaches should be developed which reach the majority of the population and which are suited to the South African context. In other words the welfare system should be more 'indigenised.'

Thirdly, the White Paper emphasises the importance of 'maximising' the 'existing potential' of the welfare system. The new welfare policy is to be implemented in a climate of financial restraint. There will be no major injection of government funds available. These broader ideas became intergrated in the the Reconstruction and Development Programme. (RDP). The RDP was designed to address the inequalities of the past whereby public investment would be used to promote development and employment, taxation would foster the redistribution of wealth and the government borrowing would increase.

In 1996, following a collapse of confidence in the currency, the government announced its macro-economic strategy for Growth, Employment and Redistribution (GEAR). GEAR focuses on the need to control government spending through a tight fiscal policy and promotes economic growth and creates employment via the private sector. GEAR's preoccupation with cutting the budget deficit, repaying the foreign debt and reducing spending was in conflict with the principles of the RDP. Although the government still maintains that the RDP is important it's once critical significance has diminished. It is clear that GEAR has

not taken into account the impact of HIV/AIDS and poverty of the majority of the people in South Africa (Sewpaul and Holsher, 2003).

The transition to democracy in South Africa saw the formation of a New African Initiative (NAI), which later became known as NEPAD. The 'African Renaissance' popularised by the President Thabo Mbeki preceded this. NEPAD was based on 2 principles i.e. that economic development is linked to the productive forces of capitalism and that political stability and accountability draw legitimacy from the will of the people. Although the objective of NEPAD was to eradicate poverty, sustain development, create peace, security and stability and achieve democratic political and economic governance, and was 'touted as the African –inspired plan for people centered development' this is unlikely to occur as the high rate of unemployment, poverty and economic inequalities associated with the neoliberal policies have pushed South Africa further into the poverty trap (Sewpaul and Holscher, 2003:62-63).

Many of the social problems and conditions that the RDP, GEAR and NEPAD are grappling with have national, regional and transnational dimensions. Today, globalisation is at the centre of economic, political, social and cultural debates. While globalisation is considered to offer great opportunities for human advancement, grave concerns remain about its threats to human security and the widening disparities between the rich and the poor. These conditions are set to emanate from the global diffusion of neo-liberal ideology and the spread of world capitalist system, which is leading to increased vulnerability of populations (Patel, 2005:2 –3). Contrary to the expectations of a post-apartheid state, the inequality of the past and the poverty gap has widened even further in South Africa (Terreblanche, cited in Sewpaul and Holsher, 2004: 3).



## **Draft Family Policy**

The AIDS epidemic will severely test the potential of child welfare organisations, which are dictated by welfare policies, to promote 'developmental social welfare' and 'community care'. These policies rely heavily on the provision of care by the extended family. Even before the advent of HIV/AIDS, the extended family networks in South Africa had been put under severe strain. Many of the socio-economic policies implemented throughout the twentieth century, culminating in the policies of apartheid, progressively disrupted family life.

Throughout the world, the family is the kinship group that forms the basic unit of society and is still recognised as the cornerstone of human society in all nations. The family is a basic unit of society and plays a key role in the survival, protection and development of children. They should be supported and their capacity strengthened to meet the needs of their members. Financial and material resources are needed e.g. employment, social and food security. Other basic services that are essential include housing, health, education, water and sanitation services. In addition services should be accessible and sensitive to the changing forms and structures of the family (Patel, 2005:167).

The implications for the family as a unit in terms of caring for children is extremely critical especially in light of the Draft National Family Policy proposed by the Department of Social Development in January 2005. In South Africa, the extended, rather than the nuclear family has been the norm. For generations, the extended family system met most of the basic needs of children and provided a protective environment in which they could grow and develop. Studies report the persistence of the extended family system in performing traditional roles even in the midst of high rates of HIV/AIDS (Ankrah, 1994). Although the African extended family is still an important factor in South Africa, its functioning as a mutual support system has been severely strained by decades of migrant labour and the policies of apartheid. Of critical significance is that as the AIDS

prevalence increases in South Africa, the safety net of the family unit might become non-existent.

The Family Policy makes repeated comments about Government's role in 'promoting and strengthening family life' and at the same time mentions 'reducing the burden on the state.' It further states that 'families should take responsibility, and not only depend on Government and others to provide. Families have a primary responsibility to care for its members. Only when the family fails to do so, the State and other service providers should take responsibility to provide. (p.63). The policy constantly speaks to the need for 'self-reliance'.

The Policy does not take into account the importance of interrelated and influential factors such as race, class, gender, denied access to power, privilege, status, resources and poverty. In addition, the policy does not consider the negative impact of globalisation in the form of neoliberalism, capitalism, and privatisation, trade liberalised regulations and economic inequalities. It also fails to consider the serious and negative impact on women who under apartheid were subject to the double jeopardy of racism and sexism in addition to poverty. The impact of problems on a massive scale such as unemployment, poverty, oppression and HIV/AIDS, is relinquished by the state and this burden is transferred onto the family who do not have the means or support to cope (Sewpaul and Holsher, 2004).

AIDS is a significant factor affecting family life and the full impact of the epidemic on families in South Africa has still to unfold. Many writers have expressed considerable concern as to whether the extended family can continue to absorb ever-growing numbers of orphans without financial and practical assistance (UNICEF, 1991; Barnett and Blaikie, 1994;Whiteside, 1996).

## **Child Welfare Organisations In South Africa**

The Child Welfare movement in South Africa came into being in 1907 as an awakening conscience of the public about the welfare of children. Child welfare societies were started in reaction to people's concern for the plight of neglected and deserted children. The movement grew as more societies were established and eventually co-coordinated their services by the establishment in 1924 of the South African National Council for Child and Family Welfare, now Child Welfare South Africa. Child welfare organisations is perceived and considered to be the leader and forerunner in our country's quest to promote and ensure the rights and protection of children whilst at the same time ensuring and implementing effective services to the most powerless of all people i.e. the children.

Child welfare organisations are non-governmental organisations but their social work salaries are subsidised by the state. About 90% of the work is statutory and the Child Care Act 72 of 1983 guides their policies and statutory work. According to Guest (2001), child welfare organisations, under apartheid adopted the policies of British and American practices and this was developed for the needy children amongst the country's 5 million whites. Since the first democratic elections in 1994, the system has been in flux. Services are now, in theory at least available to 45 million South Africans. Even without AIDS, the system would experience great difficulties in terms of coping.

The challenges regarding HIV/AIDS are not included in the traditional function of child welfare organisations. In order to meet its existing demands and the pandemic of HIV/AIDS many child welfare organisations have strenuously advocated for the expansion of the boundaries of the child welfare system. Consequently, it is believed that the organisations are failing to meet new expectations but also experiencing difficulty in carrying out its original goal of providing for children whose basic needs cannot be met by families or communities.

## **South African National Council For Child Welfare**

All child welfare organisations in South Africa are affiliated to the South African National Council for Child and Family Welfare. The main object of the movement is to protect and promote the development, interests, safety and well being of children within the context of family and community and to safeguard the rights of children.

The functions of the National Council are as follows:

- 1) To facilitate and work towards the strengthening, enabling and empowerment of affiliates and communities and to develop appropriate services.
- 2) To serve it's affiliates by providing appropriate training and or identifying resources for such training and or linking affiliates with such resources.
- 3) To assess the need for child welfare services and facilitate planning by affiliates and communities to meet these needs.
- 4) To develop and advocate said policies and minimum standards of services for children in the context of family and community.
- 5) To initiate, promote and support legislative and other measures designed to meet the needs and protect the rights of children.
- 6) To co-ordinate services within the Movement.
- 7) To co-operate with government and other organisations as the need arises.
- 8) To seek, create and maintain national and international co-operation and networks with organisations of a similar nature.
- 9) To initiate and undertake fund-raising and public relations activities for council, and where necessary, for affiliates and facilitate affiliates to undertake those functions themselves.
- 10) To identify, investigate, assess and undertake research in respect of social and other conditions, deficiencies in services and legislation relevant to the Movement.

- 11) To compile statistical data and develop guidelines to facilitate planning and rendering of services and programmes related to the needs of the nation's children and families.
- 12) In so far as it is deemed necessary to co-operate and liaise with the movement rendering services compatible with those of Council inside or outside the borders of South Africa.
- 13) To take such action and perform such other acts as may contribute towards the attainment of the Council's object (extracted from published paper: Affiliation in terms of Councils Constitution: 1999: 2-4).

### **Staffing Issues**

(Meyer, 1983) stated that for staffing patterns to be functional they have to reflect the purposes, policies and practices of the field at large and of the particular agency employing the staff to do its work. Child Welfare work is generally a social institution that is governed by social work itself. However, in South Africa it is governed by Boards of Management that consists of members that are not professional social workers. Child welfare as a field is often held in low esteem by many social workers. Some of the explanations for this are low salaries, overwhelming jobs, large caseloads, criticism of the field and low status. There is also a great deal of staff turnover and burnout. The economic and professional loss to any agency as a result of this is immeasurable and results in hampering effective service delivery.

Ife (1997) expresses a sense of outrage at the increasingly uncaring and oppressive environment in which social workers are required to work. The context of social work practice has changed significantly in the last decade. Changes in political, economic and ideological environments are seen by social workers to be fundamentally contradictory to the values of the profession. In addition, social workers find themselves in an unfriendly, if not downright hostile,

practice environment, which is problematic for someone who genuinely believes that the role of social work is to make the world a better place and to further the cause of social justice by seeking to empower the disadvantaged. This aspect is linked to advocacy.

Advocacy is an essential component of social work practice and is a concept which social work has borrowed from the legal profession. Since its inception, social work has distinguished itself from other helping professions by recognising that people's problems have both a psychological and a social dimension. In the current economic and political climate, the marginalized do not have a legitimate voice, and what voice they have is being further devalued. Increasingly, it is only the voices of the powerful, and the economically advantaged that are heard in what passes for public debate in modern society. This allows economic rationalisation and managerialism to continue largely unchallenged, as it is by and large only those who are advantaged by them who are able to have access to the media and who are able to influence policy debates. Critical theory requires that the marginalised not only are enabled to define their needs, but that they should be able to articulate them in such a way that they can be met.

Mailick & Ashley (1995), state that the use of the term 'advocacy' has always created torment, discord and discomfort among social workers. Many have come to associate it with the move towards deprofessionalisation that occurred along the late 1960s. Others reject it because they cannot support some of the Machiavellian tactics that are attributed to it. Yet, social workers have a responsibility enunciated in the Code of Ethics, to act on behalf of their clients. (National Association of Social Workers, 1980).

This is also justified in terms of the core purposes of the Global Standards Document as detailed by Sewpaul and Jones (2004:493-515). This includes:

- Facilitate the inclusion of marginalised, socially excluded, vulnerable and at-risk groups of people.

- ⊞ Address and challenge barriers, inequalities and injustices that exist in society
- ⊞ Work with and mobilise individuals, families, groups, organisations and communities to enhance their well-being and their problem-solving capacities
- ⊞ Assist people to obtain services and resources in their communities
- ⊞ Formulate and implement policies and programmes that enhance people's well being, promote development and human rights and promote collective social harmony and social stability, in so far as stability does not violate human rights.
- ⊞ Encourage people to engage in advocacy with regard to pertinent local, national, regional and or international concerns
- ⊞ Advocate for, and, or with people, the formulation and targeted implementation of policies that are consistent with the ethical principles of the professional
- ⊞ Advocate for, and, or with people, changes in those policies and structural conditions that maintain people in marginalized, dispossessed and vulnerable positions and those that infringe the collective social harmony and stability of various ethnic groups, in so far as such stability does not violate human rights
- ⊞ Work towards the protection of people who are not in a position to do so themselves e.g. children in need of care and persons experiencing mental illness or mental retardation within the parameters of accepted and ethically sound legislation
- ⊞ Engage in social and political action to impact social policy and economic development and to effect change by critiquing and eliminating inequalities
- ⊞ Enhance stable, harmonious and mutually respectful societies that do not violate people's human rights
- ⊞ Promote respect for traditions, cultures, ideologies, beliefs and religious amongst different ethnic groups and societies, in so far as these do not conflict with the fundamental human rights of people

- ⌘ Plan, organise, administer and manage programmes and organisations dedicated to any of the purposes delineated above.

### **Government's over-reliance on Non Governmental Organisations**

An unusual feature of the South African welfare system is the degree to which responsibility for the implementation of social legislation has been delegated to non-governmental organisations with special reference to child welfare organisations. In accordance with this policy, the South African government has where possible subsidised community groups to undertake approved social services rather than providing them directly. Although, there is a need for partnerships between government and NGOs, NGOs have taken the lead in providing developmental social welfare services. They have advantages over government as delivery mechanisms in that they have better information about local conditions, are less constrained by bureaucracy to respond to needs and can fulfill a watchdog role in society (Poverty & Inequality Report, 1998). However, they often do not have the infrastructure, resources nor the administrative capacity to engage in large-scale complex programmes. The NGO sector, especially child welfare organisations, are at the forefront of efforts to tackle the HIV/AIDS epidemic in South Africa.

The White Paper for Social Welfare recognises the important role, which NGOs play in the delivery of social welfare (Department of Welfare, 1997:17).

- ⌘ Innovate and pioneer new services and programmes, which if successful, can be replicated on a wider scale.
- ⌘ Respond to local needs
- ⌘ Respond speedily, appropriately and flexibly to local needs.
- ⌘ Promote grass roots participation in decision making and direct service delivery



- ⌘ Represent their particular constituencies on structures such as policymaking and co-coordinating programmes, at all levels of government to ensure that interventions are appropriate.
- ⌘ Mobilise communities to take action to meet its needs.
- ⌘ Co-ordinate action at a local level.

According to a report published by UNICEF (1998), NGOs have a natural tendency to be more sensitive than government services to human problems as they are experienced in the home and the community. They are also more flexible on policy issues. They focus on the human being and therefore tackle many dimensions of a given predicament, whereas government services compartmentalise needs, health, employment, and education and treat each one in isolation. Although these are important benefits, there are also significant problems associated with an over-reliance on NGOs. Programmes initiated by NGOs are often small-scale, reaching only a small proportion of affected people; they are often un-coordinated and frequently are not evaluated objectively. Coverage can also be patchy. Moreover, the funding of NGOs is typically uncertain and resources frequently inadequate to the task, so projects may not be serviced long enough to make a significant impact (Flinterman et al, 1992).

### **Present Trends in Child Welfare Organisations**

Current trends detect changes in the distribution of children amongst the various categories of work undertaken by child welfare organisations. The work has increased for social workers due to the need for the protection of children and the requirements of statutory interventions. This can be seen in the number of children requiring place of safety placements and children's court enquiries.

Child welfare have supported communities within its scope of functioning. This has enabled societies to establish temporary care in the absence of sufficient

state facilities. Without the involvement of community members or services, the children would definitely suffer. However, the bulk of communities in which child welfare is increasingly working are gigantically impoverished and those particular communities will soon reach the end of their capacity to volunteer help, which means that resources for support services will be depleted. In this regard, child welfare organisations have responded positively in the face of changed social circumstances in South Africa and made adjustments so as to be able to continue to serve the children.

Laudon (1996) states that the current status of the child welfare organisations supports the prediction regarding more calls for the placement of abandoned and HIV positive children, through to saturation point of extended families as they reach capacity to cope. In addition to increased caseloads the nature of social problems has also changed with HIV positive, abandoned and orphaned children appearing in steady numbers.

In terms of the confines of statutory work, placements of children 'in need of care' social workers experience a difficult and extremely time consuming nature of collecting and collating the information required by the courts and regional statutory offices in order for placements to be approved. Bottlenecks in the processing of placements seem to occur primarily at the stage of investigations by social workers. Turnover time for the foster placements from the point of application to the granting of a court order varies from 6 months to 18 months. In the rural areas this could take longer. The administrative processes for statutory placements are lengthy, time consuming and cumbersome reflecting loopholes and deficiencies in the system. In addition to high caseloads and lack of resources the increasing numbers of placements will impact on effective service delivery in terms of child protection and result in delays and create bottlenecks in an already inefficient and inaccessible system.

Child welfare organisations providing statutory services struggle to retain staff, at

least in part as a result of a lack of funding and an inability to provide salaries for social workers that are competitive with the state. This exacerbates difficulties with service provision. The circumstances faced by the social workers in rural areas highlight obstacles to inadequate service provision and provide a clear indication of some practical implications of a continued implementation of foster or kinship care placements and grants that rely on the social services or courts as a poverty alleviating strategy for orphans considering the numbers increasing to alarming proportions. As a result of social workers being inundated with ever increasing and high caseloads, social workers do not have the capacity to fulfill the range of tasks that constitute their job description and the limited nature of what they are currently able to achieve as a result of grant applications. In addition, they are unable to effectively perform their designated roles in the implementation and monitoring of home and community based care and support services.

Given the current capacity, social workers are unable to provide counselling to large numbers of children and young adults who need emotional support. As a result of the nature of the workloads, social workers play an insignificant role in assisting sick caregivers to plan for their children's future although this is clearly a social need that requires addressing. Overall social workers tend to focus on children who had been orphaned and, they are unable to render services being directed at children living with sick adults. This gap would potentially have been filled had the social workers the capacity to play their intended role in the home and community based care and support teams. The existing nature of services within child welfare organisations do not adequately address the problems related to HIV/AIDS.

The Child Care Act does not make provision for other ways of caring for orphans, such as informal care by relatives or community groups. It only deals with adoption, formal court-ordered foster care and placement in institutions. The Act defines a child as a person under 18 but it does not recognise households where

the eldest responsible person may be a child. Also, there is no comprehensive child protection system for children who are especially in difficult circumstances, such as street children and children growing up in child-headed households. In addition, the Act does not have a rights-based approach and it deals with issues affecting children in a very piecemeal way.

For the reasons outlined above and many other reasons, the South African Law Reform Commission undertook to review the Child Care Act. This culminated in a Report and Draft Bill in December 2002, called the Children's Bill.

The National Assembly passed the first part of the Children's Bill on 22 June 2005. The Bill provides a legislative framework to give effect to some of the rights of children that have yet to be fully realised, such as the right to family care, the right to be protected from maltreatment, abuse and neglect and the right to social services. It makes provision for services to support and strengthen families and for the state to provide appropriate care to vulnerable children who are in need of protection.

Some of the significant aspects included are the following. The categories of children identified as in need of care and protection have been redefined. Now only orphans without any visible means of support are included, rather than all orphans. To determine whether they are in need of care and protection, social work investigation is compulsory for children who fall into one of the following categories: street children; a child who is a victim of child labour; a child who is a victim of trafficking; a child in a child-headed household and an unaccompanied foreign child. The possibilities of a new welfare package for children included:

- ⊞ An adoption grant
- ⊞ Kinship grants for children being cared for by family members, including those who have not received the children by way of a court order

- ⌘ A supplementary special needs grant for children who need additional care, such as children with chronic illnesses and children with HIV/AIDS
- ⌘ Emergency court-ordered grants where no other grants are being received
- ⌘ Extension of the existing child support grant to be payable until a child reaches 18 years of age.

### **The Implications of the AIDS Epidemic for Welfare Policy**

AIDS will present challenges to service delivery across a wide spectrum, including health, education, employment and housing, but not least it will place huge pressures on an already over-stretched welfare budget. In 1994, the National AIDS Convention of South Africa (NACOSA) adopted a national strategy programme for HIV/AIDS. This included welfare, as one of six main components where urgent action was needed (Health Systems Trust, 1997).

The White Paper for Social Welfare (Department of Welfare, 1997) also recognises the need for action. It spells out the need for partnership between government and non-governmental organisations to devise 'appropriate and innovative' welfare services for people affected by HIV/AIDS. It again underlines the principle of community based care strategies as 'preferred options' for coping with the social consequences of HIV/AIDS. Despite this recognition at the policy level there has been little sign of effective action. This lack of action was admitted by government in 1998 when an interministerial project was established under the Deputy President's office as an attempt to promote a more co-ordinated approach (Mercury Correspondent, 19 March 1998). To date most resources appear to have been directed towards AIDS prevention and to health needs, but very little priority has been given to care and welfare.

Welfare organisations are being faced with the challenges presented by HIV/AIDS at a time when national Welfare Policy has been reformulated. Government policy as contained in the White Paper for Welfare (Department of Welfare, 1997), promotes a major shift in approach in the provision of welfare services and programmes. It exhorts organisations to rethink their whole approach to reorient services according to new values and concepts. The welfare policy is based on the principles of 'developmental social welfare' which is an encompassing concept incorporating ideas such as 'building human capacity', 'self-reliance', 'appropriateness', 'community development' and 'community care.' It recommends that organisations move towards service delivery which is 'people centered and developmental, rather than rely on strategies which are reactive and remedial.

Child welfare organisations in South Africa have tended to operate predominantly in the 'welfarist' tradition, providing institutional care and remedial or rehabilitative services. For organisations such as these, a major shift of philosophy and in methods of delivery will be required if they are to adopt the developmental strategies envisioned in the social welfare policy.

### **Children Orphaned as a result of AIDS**

One of the most tragic consequences of the HIV/AIDS epidemic is the huge number of children orphaned as a result of parents dying from AIDS. The South African AIDS epidemic is still in its early stages compared to other African countries thus the levels of orphanhood has yet to be experienced in this country (Gow & Desmond, 2002).

The country will face significant costs in the long term if the orphan crisis is not managed effectively. Such costs include increased juvenile crime, reduced literacy and increased economic burden on government. Many of these costs can

be reduced if action is taken now. It is imperative that the number and profile of orphans expected in future be understood if successful strategies to provide and care for them are to be developed. Of particular concern to child welfare organisations, is the care of the growing number of children who are infected and affected by HIV/AIDS. Existing models of care need to be assessed and altered and where possible alternate models have to be implemented in the light HIV/AIDS.

## **Models of Care**

### Family Preservation

The family as a unit has always been the prime source of protection and nurturing for children. Although the dynamics and structure of the family has changed its primary function is still resonate today. Family preservation discourages the removal of children and works with families to prevent the placement of children outside of family care. Here, social workers are seen as facilitators and become part of the community. Funding criteria are important for this (Sewpaul, 2000: 23 and 25).

In the absence of family, alternate care models such as foster care and adoption are attempts to provide a family experience for a child when the biological family cannot do so.

### Foster Care

Fostering is probably the most widely practiced form of substitute care for children worldwide. According to McGowan and Meezan (1983), foster care refers to the provision of planned, time-limited, substitute family care for children who cannot be adequately maintained at home, and the simultaneous provision of social services to these children and their families to help resolve the problems that led to the need for placement.

The fostering process, like the adoption process is lengthy. Colton and Williams (1997) identify two divergent trends in fostering internationally. The first trend is toward placing children with relatives who often receive very little in the way of financial or other support. The opposite trend is towards the professionalisation of foster parents. There are two main reasons for the second trend. First, there has been a growing recognition in many countries that caring for children who would have previously been institutionalised such as children with disabilities or life threatening diseases is a demanding task. Foster carers are increasingly required to undergo special training to develop skills which are over and above those of 'normal' parenting. Secondly, there has been a growing recognition that fostering is reliant on the availability of women's labour. The changing position of women, particularly in more affluent societies, means that ways have to be found to entice women into fostering.

There is a general agreement that fostering, rather than institutional care, should be the option of choice for children who cannot be cared for by parents for two broad reasons: Firstly, family care is preferable to institutional care for a child's physical, emotional and psychological well being. Children placed in institutions risk losing their rights to land and property as well as their identity and their cultural heritage. They are also at risk of neglect and sexual and physical abuse, since they are frequently isolated from outside sources of support (Barnett and Blaikie, 1994). Secondly, the cost of institutional care makes it a prohibitive policy option for many countries. In South Africa it has been calculated that the cost to the state of maintaining a child in institutional care is 13 times the cost of the foster care grant (Lund Committee, 1996).

Welfare organisations must find new solutions for the care of children, which make the best use of severely limited resources. The development of special foster care schemes is an option, which has not yet been given very much attention in South Africa. Such schemes require an initial injection of funds and some redirecting of resources to this area of work, but these costs are still only a



fraction of residential care. If this option is not explored, South Africa could face a similar situation to that of Zambia which has been forced to re-open orphanages to care for the growing numbers children orphaned by AIDS (Glober, 1997).

### Adoption

According to Meezan (1983), adoption is a legal process through which a family unit is created by severing ties between a child and his or her biological parents and legally establishing a new parent/child relationship between persons not related by blood. It thus involves the creation of a family by the state rather than through procreation. Through such state action the adopted child becomes a permanent member of a new family and he or she is entitled to all the benefits accredited a biological child.

Adoption as a model of care for children who cannot be cared for by their families of origin has unique advantages. South Africa has a highly specialised system of adoption based on British and American adoption practice. Historical forces such as colonialism and apartheid have profoundly affected the development of adoption practice in South Africa. Apartheid welfare policies in particular have impacted on the development of specialist welfare services in the country, rendering them virtually inaccessible to black South Africans. These factors have resulted in a system of adoption that is recognised to be inadequate to meet the needs of South African children. The demand for adoptive placement created by an apparent increase in child abandonment during recent years, has highlighted the need for a review of existing practices and policies in the South African adoption sector (UNICEF: 1991, McKerrow and Verbreck, 1995).

A major difficulty that South African adoption practitioners have to address is the historically low rate of adoption by Black South Africans. Several factors could account for this phenomenon, but principally the lack of infrastructure for adoption services in large parts of the country, as a direct result of apartheid

welfare policies and the expectation that black South African adopters have to adapt to a western model of adoption.

The key to promoting adoption lies in devising successful methods of recruitment of adoptive families, which is only the first step in ensuring the availability of sufficient numbers of adoptive parents. The process of screening and assessment of suitability has to be adapted to the South African context. Some ways include the redefinition of the family and selection criteria should include the single family. Thus, an increasing demand for adoptive care as a consequence of AIDS would require a broadening of current definitions of parenthood and parenting and a reappraisal of the qualities regarded as desirable in prospective adoptive parents. Reconciling western adoption practice with the traditional childcare practices of black families could form the basis of an enriched and viable model of adoption for South African children affected by the AIDS epidemic. South African adoption practitioners should be encouraged to make use of the opportunity to develop a model of adoption that combines both western and non-western traditions (Harber, 2000).

#### Alternate Community Care Models

Child welfare organisations will find it increasingly difficult to cope with the heavy increases in alternate care placements unless they make changes to the ways in which they deliver and manage this service. A considerable amount of time is required to successfully place, monitor and complete statutory requirements for this type of care. At present, cases are not flowing smoothly through the system. Many more applications will simply choke the system and place an impossible strain on the welfare system. As with family preservation, the ideal is to allow children to remain with their families of origin. However, this ideal is often jeopardized and traditional residential care facilities are insufficient to meet the growing numbers of children, thus alternate models of community care is an option to be considered in view of the HIV/AIDS challenge.

In addition, child welfare organisations are faced with a huge task, not only must they find strategies to tackle poverty and redress inequalities created by apartheid, but they must develop effective models of care to support children and families affected by this rapidly spreading pandemic. In South Africa, child welfare organisations have been instrumental in developing and administering a range of community care options to meet the growing needs of placement of children as discussed below.

### Community Homes

This is a type of community family care, which was a model of substitute care, whereby a child's own family cannot raise the child. It is designed to provide affordable, family-type care for 5 or 6 children of different ages and both sexes in a racial, cultural and social context similar to that of their community of origin. The 'family group home' concept is a development of the cottage system. It has been implemented overseas and is in line with 'permanency-planning' principles as set out by the Department of Welfare and professional thinking regarding placement of children. This form of placement, by caring for 6 children, potentially also provides more placements and therefore supplements the currently limited supply of foster parents (Neilson, 1999:11).

### Models of informal Child Care

This model mainly rests on the responsibility of women within a particular community. The main purpose is to ensure the safety and care of the children and provide an opportunity for poor parents to go out and work knowing that their children are safe, fed and cared for and it can fill the gaps in parental care and through community participation whereby support and capacity building, takes place and self-reliance is achievable. Difficulties are experienced e.g. lack of funding and resources and lack of commitment. However, this model is affordable, relevant to the South African context and replicable. It is also reflected in the practice principles of the White Paper for Social Welfare (Sewpaul, 2000:30).

### Group Models in Alternative Care Placements

Toseland and Rivas (cited in Sewpaul, 2000: 37) defined group work as a goal directed activity with small groups of people aimed at meeting socio emotional needs and accomplishing tasks. The activity is directed to individual members of a group and to the group as a whole with a system of service delivery. Thus groupwork is a planned a purposeful activity.

The most compelling rationale for the group work method was the high caseloads that social workers were dealing with and the infrequent contacts between social workers and the foster care system. The advantage is that the therapeutic value of universality helps to contribute to positive living by normalising members experiences of and their affective responses to issues such as foster care, trans-racial placements and HIV/AIDS (Sewpaul, 2000:31)

### Innovative Fostering Schemes in Africa

There are only a few examples of innovative fostering schemes in Africa. One approach is for children orphaned as a result of HIV/AIDS living on commercial farms in Zimbabwe. Approximately, one million children live on these farms. Their parents tend to be isolated from their extended family, which means that when they die, care options outside of the extended family need to be sought for the orphans. The Farm Orphan Support Trust (FOST) is working closely with the Zimbabwe Department of Social Welfare to pilot and monitor different models of foster care. The models identified so far include recruiting older women to care for a number of children, appointing older siblings and neighbours to oversee the care of young children and encouraging families to care for non-related orphaned children without having to undergo legal formalities. Benefits have been identified as minimising disruption for children, keeping siblings together, preserving children's culture and identity, promoting community involvement, protecting future employment opportunities in agriculture for children and being a relatively low cost option. Nevertheless schemes such as these require resources. FOST has recognised that competition for international funds will increasingly outstrip

supply as the AIDS epidemic spreads. Innovative forms of funding to enable the expansion of the scheme are being explored. These include raising funds from the business sector as well as identifying areas of indirect government support, such as free education and health care for orphans and the possible introduction of tax credits for farmers who provide good schemes (Parry, 1996).

### Intercountry Adoptions

Intercountry adoption, as regulated by the Hague Convention which is an intergovernmental organisation that aims to work for the progressive unification of the rules of private international law, recognises it as a means of offering the advantage of a permanent family to a child for whom it is not possible to find a suitable family in the child's country of origin. On 15 May 2002, the South African cabinet supported the ratification of the Hague Convention as it would guarantee the protection of the fundamental rights of children from being sold or trafficked between parties or countries. South Africa ratified the Convention on 21 August 2003; however, the processes for implementation of the Convention are not in place. The Child Care Act 72 of 1983 makes no provision for inter country adoptions. However, the Children's Bill provides for this, but there is no indication as to when the Bill will be enacted. In 2003, the Department of Social Development advised that they are in the process of acceding to the Convention and will accredit agencies to deal with inter country adoptions. The Department also stated that they are aware of the need for this type of adoption and believe that it could be a solution for many children desperately needing homes (Durban Children's Society: Report on Study Tour: 2004)

### Street Shelters

Street shelters are a much-needed response to the needs of street children and need to be a part of an integrated service. The service is cost effective as it is community centered, utilising existing community infrastructure and does not remove children from the community into institutions. This together with a

dedicated trained care team of personnel allows for the provision of remedial, preventative, re-unification and developmental services (Sewpaul, 2000).

### Volunteer Participation

In the face of rising case loads, diminished resources and the call for community involvement and new ways of working, many organisations have been recruiting, training and utilizing volunteers for particular aspects of their work. Volunteers have the capacity to reach far more people than the limited numbers of professional service providers and are generally more accepted than social workers. The use of volunteers in early intervention and prevention means the need to decrease statutory services, which currently makes up the bulk of social worker's caseloads in child welfare organisations.

For efforts to be replicable, viable and cost-effective, it is important to develop mechanisms to ensure that codes of conduct are adhered to and due to the lack of men, agencies should target men as part of their strategy. According to Patel (2005:108) the volunteer labour is worth R5.1 billion.

### Models of Intervention with Women and Young Children

The main objectives of intervention with women and young children are to provide nurturance, stimulation and protection for children through capacity building and support of their mothers. The rationale was that women who are trapped in the poverty cycle cannot provide adequately for the educational, social and health needs of their children. The feminisation of poverty is a major concern in South Africa and female-headed households tend to be poorer than male-headed households. The main objectives are protecting women from abuse and neglect and it embraces the aims of self-sufficiency, self-reliance and empowerment through skills training and income-generating programmes (Sewpaul, 2000:47).

At present, a variety of models of care for orphans exist in South Africa. As the number of orphans increase some or all of these models will have to be

expanded to avoid a rapid increase in child-headed households and street children. The quality and costs of care differ. Failure to consider the costs and quality of care offered will likely lead to inefficient allocation of resources and inappropriate care of children, the long-term implications of which are far reaching.

### **Governmental Support**

In terms of community programmes and projects, some of the constraints or difficulties include:

- ⌘ Lack of government commitment to providing a safety net for the poor.
- ⌘ Shortage of staff.
- ⌘ Lack of material capacity by communities and limited resources.
- ⌘ Lack of volunteers.

Thus, it is important for government to facilitate this by developing an enabling environment and it is unacceptable for government to simply shift responsibility onto the community. While the government uses unaffordability as the reason for lack of investment in human capital formation and community development initiatives, misplaced priorities may be the real concern "When it comes to bidding for the Olympic Games or the Soccer World Cup, South Africa portrays itself as a 'First World' country with all the necessary infrastructure, security, etc. but when it comes to meeting the needs of its children, it hides behind its 'Third World' status and lack of infrastructure" (Children First, 2003:4).

### **Social Work in Perspective**

According to Mullaly (1993), the need for an alternative i.e. structural rather than

conventional social work is more obvious today than ever before. Conventional social work appears powerless to deal with the increasing number of social problems that have already overloaded a diminishing welfare system. By not changing its theories and practice, conventional social work contributes to the ideological hegemony of patriarchy, classism, racism and other oppressive structures. He provides a comprehensive and integrated picture of an alternative to conventional social work. The welfare state is in a profound state of crisis and restructuring and can only be understood within the context of the larger international economic crisis.

The effects of governments cutting back on social expenditures are obvious to all who either depend on or work within social services. The very nature of welfare itself has changed. Government has relinquished its responsibility for assuming that many people's social rights are protected by reducing its involvement and by transforming much of its responsibility to the private sector. Voluntarism, privatisation and self-help are replacing many programmes including the provision of basic life-sustaining benefits and services.

The crisis in social work is manifest at all levels and in all areas of social work activity. At the delivery level, there have been cuts in social expenditure, increased categorisation and targeting of programmes, privatisation of many public services, increased unemployment, etc. The net effect is that it is now impossible to address the economic and social needs of increasing numbers of people in a meaningful way, particularly the poor, the deprived and the most exploited. This situation makes it more difficult for people in need and has made the job of social workers more frustrating.

On an employee level, social workers are being affected by society's priorities, which lie in industrial enrichment and public order rather than in the well being of the general population to meet those priorities. Social workers are asked not only to sacrifice their own living standards through wage control but to police



casualties of unemployment, inflation, economic neglect and policies that place private profit above human need.

Higher caseloads, deprofessionalisation of social work, increased use of volunteers and the use of consumers as providers of service all suggest a deprofessionalisation of social work in that many traditional social work tasks and functions are now being relegated to untrained persons (Mullaly, 1993).

Many have criticised the present social order because of its failure to provide satisfying levels of living for large numbers of citizens. This is important for social work because they identify the reasons for many of our social problems and show us what it is we are struggling against. A goal is a conceptualisation of a society in which every person is afforded maximum opportunity to enrich his or her spiritual, psychological, physical and intellectual well being (Collins, 1993). Because the profession of social work is founded on humanitarian and egalitarian ideals, those must form the cornerstone of an ideal society.

Reynolds (1993) viewed the rise of radical social work as consistent with the ethics and values of the profession. The feminist perspective is an epistemological imperative for radical social work, it not only decodes sexism and patriarchy but also links the personal and political better than any other theory and emphasises that transformational politics and transformation is not limited to women but end of domination and oppression of all people.

The personal is political is a slogan associated with the feminist movement. Social- economic political context of a society is critical in shaping who we are in terms of our personality formation and what we are in terms of our personal situation. If the personal is political then the political is personal too. For structural social work the political end is to change the status quo and leave oppression behind. Structural social work owes a great deal to feminist analysis. It has

shown us the nature and extent of patriarchy in our society and it has given us ways of dealing with women's oppression that do not further contribute to it.

Empowerment as a goal and a process has been identified as a major goal of social work intervention, whereby a major function is to empower people to be able to make choices and gain control over their environment. Empowerment is typically understood as a process through which people reduce their powerlessness and alienation, and gain greater control over all aspects of their lives and their environment.

## **Conclusion**

The aim of this chapter was threefold: Firstly, to review relevant literature with a view to introducing and defining concepts which have influenced the development of welfare internationally and in South Africa. Secondly, to provide a broad understanding of the context within which child welfare organisations in South Africa, including KwaZulu-Natal are operating. Thirdly, to contextualise challenges that HIV/AIDS poses for child welfare organisations in South Africa, including KwaZulu-Natal.

The next chapter examines the importance of poverty and outlines important aspects relating to social security in South Africa.

## **Chapter Four**

### **SOCIAL SECURITY IN SOUTH AFRICA**

#### **Introduction**

Poverty is broadly explained as being caused by either individual pathology or structural forces, which create and perpetuate poverty. Apartheid, unemployment, globalisation and AIDS are structural components that have contributed to the high rate of poverty in South Africa. One of the biggest challenges is to improve the social security system whereby the majority of the people who live in impoverished circumstances are captured in the safety net of a well co-ordinated, accessible and comprehensive social security system (Patel, 2005).

In light of the above, this chapter provides an overview of Social Security in South Africa. However, as Poverty is a critical and key component within the South African context this concept will be discussed first. The chapter then progresses to outline the various types of grants available, suggestions for improvements to the existing system are also mentioned and concludes by questioning social security provisions for children in South Africa in the context of HIV/AIDS.

#### **Definition of Poverty**

“Poverty is the inability of individuals, households or communities to command sufficient resources to satisfy a socially acceptable minimum standard of living. However, poverty is more than merely income insufficiency. It also includes the lack of opportunities, lack of access to assets and credit, as well as social

exclusion. Poverty is a complex, multi-faceted and fluctuates in depth and duration (Guthrie, 2002:122).

Narayan and Budlender (cited in Patel, 2005:241), state that poverty is an interlocking and multidimensional phenomenon caused by a lack of multiple resources such as employment, food, assets such as (housing, land), basic infrastructure (water, transport, energy), health care and literacy. Poor people have also highlighted the psychological aspects of poverty and these include humiliation, inhuman treatment and the emotional strain of living in poverty. The lack of political voice that can be heard by society and decision-makers is another aspect that is important in defining and addressing poverty.

### **Impact of Poverty**

According to the Sunday Tribune (8 /11/05), it is said that every breadwinner who dies of AIDS in this country, leaves behind an average of four dependants who will be in need of subsistence. In 2005, it is estimated that more than 400 000 victims will die, so if only half of them are breadwinners, this means that the poverty stricken population in this country will increase by 800 000. This figure is alarming considering the existing high poverty prevalence.

At least 22 million people in South Africa live in poverty. Even in the new South Africa, poverty remains strongly correlated with race, gender and urbanisation. Of those people living in poverty, 94% are African and more than 70% live in rural areas and households below the poverty line are twice as likely to be headed by women as by men. Meanwhile, 1 in 8 South African spend, on average, more than R2000 on consumption each month. Nearly three-quarters of this group is white and the overwhelming majority are urban dwellers. In fact, South Africa has become possibly the most economically unequal nation on earth. Such enormous disparities pose a grave threat to the stability of our society, the future of race

relations and the sustainability of our internationally admired transition to democracy.

"Poverty in South Africa is critically linked to the labour market" (Taylor Committee of Inquiry into a Comprehensive Social Security System, 2002:70). The evidence provided by the Labour Force Surveys cited in Guthrie (2002) indicates that the unemployment rates are rising: from 33.0% in 1996 to 37.0% in February 2001, to 41.8% in September 2002. So it may be assumed that the number of people experiencing dire poverty is also increasing. It was also found that in 2000 at least 45% of the South African population lived in absolute poverty, i.e. less than \$2 per day. According to the Poverty and Inequality Report in South Africa (May 2003:41-43), the total number of poor people in 2002 estimated to be 21.9 million. In addition, it was also reported that poverty has gender, race, family type and spatial dimensions. A total of 54.4% of the poor are women, of the total population 56.3% are Africans, 36.1% are coloureds, 14.7% are Indians and 6.9% of the white population live below the national poverty line. They also found that poverty is most concentrated in the Eastern Cape, KwaZulu-Natal and Limpopo provinces where 59% of the country's poor population live.

According to the Sunday Times (23 July, 2002), it was found that 75% of South Africa's population have inadequate access to food and according to Statistics South Africa (2001), more than half of the children under 5 are in poverty-stricken non-urban areas ie. 61.8% of African children, 20.5% coloured children, 6.6% Indian and 9.4% white children. Guthrie (2002:122-145), warns "Existing levels of poverty have reached unsustainable levels, and if left unattended have the potential to reverse the democratic gains achieved since 1994. The urgent need to address deepening social exclusion and alienation of those households living in destitution cannot be ignored."

Nobody would deny that there has been monumental change since 1994, but, as Guthrie (2002, 4) cites Terreblanche (2002) who asserts “while South Africa experienced a remarkable political transformation in 1994, there has been no parallel socio-economic transformation. We have in fact gone backwards.”

Within this context, the situation for most South African’s appear to be worsening with the impact of HIV/AIDS pandemic being felt at every level of society. It is argued that the ethics of the state providing support for poor relatives to care for children, without providing adequate and equal support to biological parents living in poverty to care for their own children is questionable. The question that needs to be asked in terms of the Child Care Act No. 74 of 1983 and the Social Assistance Act No. 59 of 1992 and replicated in the proposed Children’s Bill is why, in the context of widespread poverty, children in the care of relatives should require special grants that are different to children living with biological parents. This applies to terminally ill parents who also face increased financial struggles to care for their children.

### **Social Security in South Africa**

There are differing theoretical perspectives on the response to societal need. These may be viewed, along a continuum, either in terms of the degree of support for a collective commitment to welfare and social security provision, through the state, on the basis of need, or support for a market-based society that maximizes the scope of individual choice and relegates the state to a minimal ‘safety net’ role (Williams 1989: 18-22). Generally, social security interventions are attempts by the state and society to protect members from the loss of income and the extra costs due to social contingencies, or risks, such as employment, disability or pregnancy.

The government has acknowledged the challenges of persistent structural unemployment problem and associated household poverty and has therefore initiated efforts to alleviate poverty. Some are specific while others are general. Social security are attempts by the government to alleviate poverty and there is no doubt that social security can benefit families. The government accepts that well-targeted and well-managed social security can play an important role in meeting basic needs and alleviating poverty (Department of Finance, 1998:1.3).

The South African White Paper for Social Welfare describes social security as "a wide range of public and private measures that provides cash or kind, in the event of an individual's earning power permanently ceasing, being interrupted, never developing, or being exercised only at unacceptable social cost and when such a person is unable to avoid poverty and secondly, in order to maintain children. The domain of social security is poverty prevention, poverty alleviation, social compensation and income distribution" (Department of Welfare and Population Development 1997:48).

The South African social security system has been described as generous, redistributive and as being exceptional in the world for a country of South Africa's level of development (Seekings 2002:1). At the same time, the system is fragmented and non-comprehensive, with many vulnerable groups falling 'through the cracks.' In addition, the existing provisioning is plagued with administrative problems and other barriers to accessibility. It would appear that, while the current grant system is an important poverty alleviating mechanism, all those are not freely accessing it in need.

The Impact of Social Security Cash transfers on Children. The impact of cash transfers on the well-being of children has been quantified to some extent e.g. the State Old Age Pension is reportedly a very important source of income for poor households. In April 2003, 2 million elderly people were receiving the grant. Ardington and Lund (1994:19) identified the general benefits of pensions:

- ⌘ They comprise a significant source of income, with definite redistributive effects.
- ⌘ They are a reliable source of income, which leads to household security.
- ⌘ They are the basis of credit facilities in local markets, further contributing to food security.

Guthrie (2003:22) found the following regarding the expenditure on each grant for the period 2001-2003.

- ⌘ The proportion of expenditure going to three child grants i.e. the child support grant, foster care grant and care disability grant increased from 11% in April 2001 to 21% in April 2003.
- ⌘ The number of Child support grants has doubled from 8% to 16% from April 2001 to April 2003, the foster care grant share has increased from 2% to 3% and the care disability grant has also doubled from 1% to 2%.
- ⌘ The Child Support Grant experienced the largest increase of 250% during the period 2002-2003, the Care Dependency Grant the next largest increase of 117%, which would indicate improved access to children with disabilities.

While the increased numbers of children benefiting is welcomed, when one considers the numbers of children in need, it was found that the Child Support Grant was only reaching 50% of those under 11 years (in April 2003), with large variations between provincial access. In 2003, the government announced a further age extension up to 14 years.

However, this age extension will be effected in phases. At the end of November 2002 there were 5.4 million children in receipt of the child support grant (Department of Social Development Fact Sheet 2003:2). Bredenkamp (1999:238) concludes "... the child support grant is set at too low a level and offered for too limited a duration to have as great an effect on poverty alleviation in recipient families as the old state maintenance grant did. However, its design is such that



it can potentially do far more to alleviate poverty among families with children...the biggest challenge now is to increase take-up rates so that the positive impact of the design elements can be felt." According to South Africa's Constitution (Section 27(1) (c)) everyone has the right to social security if they are unable to support themselves and their families. The state has a responsibility to ensure that this right is realised. The Social Assistance Act (no. 59 of 1992) records that it is the constitutional right of people who qualify for social assistance to claim their grants.

It is important to note that there are no grants available to HIV positive people. During the initial phases of HIV infection, people may be able to work and support themselves. However, during the latter stages of the illness they may become so sick that they are unable to do so. The government is responsible for providing social assistance grants of people who are no longer able to care for and support themselves and their dependants.

The government has made grants available to citizens of South Africa each differing in amount, age and requirements. The grants are the child support grant, the foster care grant, the care dependency grant and the disability grant. These will be discussed separately. Of the three child grants, the Child Support Grant is the most accessible and widely adopted. The child support grant has currently reached 85.16% of the 3 million-child targets but there are problems of accessibility reported from rural areas and failure to obtain full documentation requirements. The Fourth Annual Economic and Social Rights Commission report (2003) indicates that the poor take-up rates of Child support grant is due to inadequate administration skills and corruption in government offices. Essentially the problems identified in the literature to gain access to the child support grant are related to lack of awareness and identity documents or birth documents (Nhlapo, 2002;Ewing, 2002.). Orphaned and other vulnerable children are not sufficiently protected by the state and are increasingly vulnerable to exploitation, child labour and prostitution.

Ewing (2002) highlights the relationships between the prevalence of HIV/AIDS and its effects on child support grants accessibility. Grandparents are often left with their children's' children having died of AIDS with no proof of identification cards or proof of guardianship. Cases have been known to show grandparents caring for up to 15 children some of whom have HIV and even if all identity cards are available, only 6 out of 15 children could be awarded. Geographically, those living in rural areas have trouble reaching the welfare offices as it is time consuming and too expensive to travel. Up to 51% of children do not have birth certificates in South Africa therefore families living in poverty are denied access.

Foster care grant is the next type of grant. However, in terms of its higher value compared to the child support grant, the number of children accessing this grant remains low due to problems of accessibility. As the number of HIV/AIDS children increase so does the reliance on this grant with an estimated 300 000 orphans in 2002, 72 000 in foster care. In the next 10 years 3 million orphans as a result of HIV/AIDS are expected in South Africa. Provincial welfare budgets do not allocate for the foster grant, therefore the government assumes that caregivers will not be applying for the grant (Ewing, 2002). This will cause an inevitable problem in the future. However, access to this grant has increased since 2000 and the rise could be attributed to the rising rates of AIDS.

The care dependency grant is for children with disabilities, but rural communities lack access to this grant compared to urban areas. There are no specific grants or assistance to children with HIV/AIDS and only few cases have been successful in applying for this grant when children develop AIDS (Ewing, 2002).

To qualify for the disability grant, the applicant must be a South African citizen resident in South Africa at the time of application. Women must be between 18 and 59 years old and men 18 to 64 years old. The application should not be receiving another grant and should not be living or cared for in a state institution. Applicants will only qualify for this grant if they are incapacitated and unable to

get any type of employment. People living with HIV/AIDS are only eligible for a disability grant if they are too sick to work. A person with HIV/AIDS who is unemployed and unable to find a job will not receive a grant. The numbers of individuals receiving disability grants have increased from April 2000 to 2003 by 57%. The numbers reached 1 292 426. The growth may be attributed to the rising numbers of people who are HIV positive (Patel, 2005:130).

### **Government Welfare Policies for Children**

Due to general service delivery problems and shortcomings on the part of the social security system focused on children, the welfare system is failing to reach most children, especially orphans. Children's rights and welfare organisations nationally argue that ensuring access to existing benefits is an essential and an urgent step, while implementing a basic Income Grant and targeting special assistance to vulnerable children.

About 750 000 children receive the primary grant i.e. the Child Support Grant. But, there are about 4 million children living below the poverty line, which means that only 18% of children that are desperately in need of income support receive the grant that they are entitled to. Bearing in mind the link between HIV and income poverty, a large portion of the children in need and who are not receiving the grant will be suffering from the HIV/AIDS impacts described earlier.

Clearly, government has been making progress in trying to ensure that the grant is paid to children in need but it is struggling in this regard. The key implementation problems explaining why few children qualifying for the Child Support Grant are receiving it are (Sedan & Streak, 2000):

- ⊖ Lack of transport and money to get to the relevant government social development office to start the application process, particularly in rural areas.

- ⊞ Lack of physical infrastructure.
- ⊞ Denial of the grant because the surname of the child on the Road to Health Card is not the same as the caregivers (a situation that is common when the primary caregiver is the grandmother).
- ⊞ Lack of birth certificates and identification documents.
- ⊞ Lack of information about the availability of the grant.

The current social security system is fragmented and non-comprehensive, with many children falling between the gaps. The key shortcomings in the design of the social security system that are ensuring that it is unable to catch sufficient children are:

- ⊞ The age limit on the child support grant is restrictive as many of the orphans and other children in need are until the age of 19.
- ⊞ The need for the caregiver to supply the birth certificate of the child when applying for all the child specific grants. After the death of a parent/parents it may be difficult to access the document and commonly the surnames of the grandmother and child are different.
- ⊞ The nature of the process involved in deciding which children are eligible for the Child Dependency Grant. To become eligible for the grant, a child has to be classified as requiring permanent home care due to his or severe mental/physical disability. The 'permanent home care' criteria are very exclusionary and in practice, the decision for giving child eligibility is subjective.
- ⊞ The requirement that the Foster Grant only be given to foster caregivers after the court has placed the children in the care of these caregivers and the fact that the number of foster children is limited to six. Foster mothers outside the formal system commonly look after more than 6 children.

The process is currently underway to redesign the social security system, including the child specific part of it. In May 2000, Cabinet appointed a Committee of Inquiry into a Comprehensive Social Security System to develop a

framework and policy options for social security in its broad sense of social protection. The committee's brief includes making recommendations for the redesign of the child specific portion of the system with particular reference to ensuring that it catches orphans. The committee is consulting with civil society in developing its recommendation. There has been talk of merging the three grants into one grant so that all children aged zero to 17 have access to these grants and having additional grants to service children with special needs such as children with particular disabilities including HIV infection and AIDS. The importance of linking income payments to free schooling, health care and food vouchers has also arisen. However, children made vulnerable by HIV/AIDS are at the moment potential beneficiaries of the three grants outlined above.

### **Questioning Social Security Provisions for Children in the Context of HIV/AIDS**

According to the Fact Sheet: Social Assistance Provisioning for Children in South Africa (2001), current projections estimate that by 2011 the total number of HIV infections will reach 5.8 million and the AIDS death toll will top 5.5 million. One in 4 working age adults will be infected with HIV and 1 in 6 will have succumbed to HIV/AIDS. If this is proved correct, over half of the population will be in households where at least one member is living with HIV/AIDS or has died from the disease.

There is much debate regarding appropriate social security provision for children in the context of HIV/AIDS. It has been argued that the most equitable, accessible and appropriate mechanism for supporting children in the context of the AIDS pandemic would be through the extension to all children of BIG (Basic Income Grant) for the means test to be removed. Progressive implementation of a universal grant should be based not on providing grants in the interim to particular categories of children such as orphans but rather on drawing on more

impoverished children irrespective of their parental circumstances into the social security 'safety net.'

In July 2001, a group of 12 organisations announced the formation of a Basic Income Grant (BIG) Coalition. They proposed a grant of R100 per month for all South Africans. It was noted that At least 22 million people in South Africa-well over half the population live in abject poverty. They estimate that the poverty gap can be closed by 80% and proposed the grant be financed by a progressive taxation system and estimated net costs after tax offsets would be R20 to R25 billion annually.

The idea of a Basic Income Grant received important support in the Consolidated Report of the Committee of Inquiry into a Comprehensive Social Security System for South Africa (also known as the Taylor Committee), which was released by the Minister of Social Development in May 2002.

The growing unemployment and inequality in South Africa means that we are faced with two options to really impact the quality of life of families. The first is to increase labour-absorbing capacity to ensure gainful employment for people. Sewpaul (2005) maintains that in the absence of employment, decommodifying basic services such as health, education and water together with a comprehensive social security in the form of BIG can alleviate poverty and enhance the lives of the majority of people.

The partial means-tested grants, according to the Economic Policy Research Institute (cited in Sewpaul, 2005) closes the poverty gap by 23% and it excludes those poorest households that do not have members receiving UIF, state old age pensions, disability grants or children qualifying for grants. Even with full uptake of the existing grants, for those who qualify within the designated categories, it will reduce the poverty gap by only 36%. With universal coverage a BIG, most of which could be recovered through a means of taxation and thus constitute a non-

threatening means of redistribution would close the poverty gap by about 74% (EPRI, 2001).

Research commissioned by the Department of Social Development cited in Sewpaul (2005) provides some compelling evidence for the developmental benefits of social security, confirming that social security must be seen as an investment in people rather than a drain on the state. The key findings can be summarised as follows:

- ⊗ Social security assists in reducing poverty, promoting job research and increasing school attendance.
- ⊗ Social security reduces the rates of hunger and increases nutritional outcomes, especially among children.
- ⊗ Social grants are positively associated with lower spending on health care, The World Bank, for instance, identified the link between education and preventing the spread of HIV/AIDS.
- ⊗ The profound effects of social security on labour productivity and the ability of people to find jobs. Employment in turn facilitates access to resources and promotes education, nutrition, health and other outcomes.

There is a general tendency to claim that social security grants undermine labour force participation by creating dependency and laziness. The study by Samson et al (cited in Sewpaul, 2005) that specifically examined this, support the following:

- ⊗ Social grants provide potential labour market participants with the resources and economic security necessary to invest in high-risk/high reward job search.
- ⊗ Living in a household receiving social grants is correlated with a higher success rate in finding employment.
- ⊗ Workers in households receiving social grants are better able to improve their productivity and as a result earn higher wage increases.

Despite the support for the Basic Income Grant and the findings of the Taylor Committee the government has not been won over. Minister of Finance Trevor Manuel, in his February 2004 Budget Speech, said he had sympathy for the underlying intent of BIG but that "Government's approach, however, is to extend social security and income support through targeted measures and to contribute also to creating work opportunities and investing further in education, training and health services. This is the more balanced strategy for social progress and sustainable development."

## **Conclusion**

In studying economic and political settings connected with a high prevalence of HIV/AIDS, social scientists have concluded that there is a clear link between levels of HIV/AIDS and poverty throughout the world (Frudenthal, 2001). There exists a broad consensus that comprehensive social security is critical in terms of alleviating poverty and enhancing the lives and well being of the majority of the population in South Africa. A comprehensive, well co-coordinated and accessible system is required that is redesigned for the South African context as present methods and strategies are unco-coordinated, fragmented and inaccessible.

The current social assistance system is ill equipped to deal with the HIV/AIDS pandemic. The support given is insufficient to absorb the additional burden that affected households have to carry. Those most affected by HIV/AIDS i.e. the working age adults have very little access to social grants, resulting in a dramatic increase of the number of people with no income whatsoever. In view of this progressive civil society groups in South Africa are advocating for universal social security coverage in the form of a Basic Income Grant.

Part Three, Chapter Five examines methodology for the research study in detail.



# PART THREE

## **PART THREE: DESIGN**

### **Chapter Five**

#### **METHODOLOGY**

##### **Introduction**

This chapter outlines the methodology used for the study and focuses on the research design, the sampling strategies, and data collection tools and data analysis. It also examines the ethical considerations and concludes with a discussion of the limitations and strengths of the design and methodology.

##### **Research Design**

Blaikie (2000:36) states that “a research design designates the logical manner in which individuals and other units are compared and analysed. It is the basis for making interpretations from the data. The purpose is to ensure a comparison that is not subject to alternative interpretations.” Of importance is that it is “the plan, structure and strategy of investigation conceived so as to obtain answers to research questions and to control variance. The plan is the overall scheme or program of the research. It includes an outline of what the investigator will do from deciding on the topic to the final analysis of the data” (Pedhazur 1973:300).

In developing this research design, the researcher made a series of decisions along 4 dimensions as stated by Durrheim et al (1999). These included:

- ⊗ The purpose of the research
- ⊗ The theoretical paradigm informing the research
- ⊗ The context or situation within which the research is carried out and

- ⌘ The research techniques employed to collect and analyse data.

Multiple considerations derived from these 4 dimensions were woven together in a coherent research design in a way that maximised the validity of the findings. A good research design is both valid and coherent (Durrheim et al, 1999).

The triangulated research paradigm, which incorporated both the quantitative and qualitative methods, were utilised, as this was the most appropriate approach for the study's focus, objectives and research questions. For a better understanding of these methods, the concepts quantitative, qualitative and triangulation will be discussed separately in relation to its relevance to the research study. By combining these 2 methods a general overall audit or snapshot was possible in addition to obtaining rich, in-depth information by utilising 55 child welfare organisations as the sample population of KwaZulu-Natal via mailed questionnaires using both open and closed-ended questions and by conducting personal in-depth interviews by selecting 4 senior social work personnel from the child welfare organisations already targeted. By combining these 2 methods, it enriched the study and ensured that a maximum number of dimensions of the phenomena under study were tapped. This helped the reliability and validity of the findings.

### **Quantitative method**

According to Cresswell (1994:1-2), "a quantitative study can be defined as an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers and analyzed with statistical procedures in order to determine whether the predictive generalizations of the theory holds true."

## **Qualitative method**

According to McRoy, cited in Delport (2002:79), "The qualitative researcher is concerned with understanding rather than explanation; naturalistic observation rather than controlled measurement; and the subjective exploration of reality from the perspective of an insider as opposed to the outsider perspective that is predominant in the quantitative paradigm. As such qualitative study is concerned with non-statistical methods and small samples often purposively selected."

## **Triangulation**

An outgrowth of the debates about the relative merits of qualitative and quantitative methods has been expanding the chorus of support for the ideas of combining different types of methods (Blaikie, 2000). Recognising that all methods have limitations, researchers felt that the biases inherent in any single method could neutralize or cancel the biases of other methods. Triangulating data sources, a means for seeking convergence across qualitative and quantitative methods were born (Cresswell, 2003).

Denzin (1970) coined the term triangulation to refer to the use of multiple methods of data collection. These concepts relate to the use of a variety of methods, which, as a result of their complementarity, may be employed to correct for their respective shortcomings. From the original concept of triangulation emerged additional reasons for mixing different types of data e.g. the results from one method can help develop or inform the other method (Graham et al, 1989).

In this design, the researcher first collected the data for quantitative research, followed by obtaining data for qualitative research separately and then integrated the information in the interpretation of the overall results.

The researcher bore in mind that, “triangulation as a strategy provides a rich and complex picture of the social phenomenon being studied” (Mathison 1988:15). For this research study the descriptive design was chosen over the exploratory design. The reasons for this are that according to Grinnell (1981), it is more extensive and it aims to secure detailed data about an entire population. The descriptive design is also characterised by more systematic and rigorous techniques for sample selection and for collecting and analysing the data.

According to Smith et al (1989: 70-71) “ The descriptive function involves primarily the delineation of characteristics of social systems, target problems and interventions. It encompasses not only delineation of phenomena in a holistic fashion but also specification of how different parts are related. In fact, the logic of this function is to break wholes down into interconnected parts, to achieve a detailed a picture as possible. It delivers information about the presence of association among factors and does not point to causal connections.”

The descriptive function plays an important role within this research context as it has developed knowledge about client needs, problems and attitudes about the nature of services provided in terms of the responses of child welfare organisations towards HIV/AIDS in Kwazulu-Natal.

### **Questionnaire Construction and the Pilot Study**

According to Macleod (1999) pilot studies are used to identify possible problems with proposed research using a small sample of respondents before the main study is conducted. Pilot studies may take on 2 forms depending on the nature of the research. The type relevant to this research was more free range and proved useful in exploring the potential issues pertinent to the study prior to a more structured format being put into place. The drafting of questions is a crucial aspect of developing any assessment instrument. To validate the study the questionnaire

was initially developed by the researcher and thereafter 8 experts in the field of HIV/AIDS were consulted in terms of their professional knowledge in the subject area. Insightful comments and constructive criticisms regarding the format and content of the questionnaire assisted the researcher in the process of refining the questionnaire in terms of the research aim, objectives and research questions. The rationale for a pilot study is to save time and money in the main study. For the quantitative approach, questionnaires were utilised and for the qualitative approach, interviews were conducted. The details pertaining to the methodology of questionnaires will be highlighted first, followed by a discussion on the important elements of interviewing as incorporated in this research study. In terms of formulating the questionnaire a first draft of the questionnaire was outlined. Here, the outline and topics for questions were listed. At this stage of questionnaire construction the researcher read various literature regarding the subject. In addition various ideas and suggestions from colleagues were also taken note of.

According to Macleod (1999) pilot studies are used to identify possible problems with proposed research, using a small sample of respondents before the main study is conducted. In the process of revision and re examination of questions is invaluable to supplement one's own efforts by the critical reactions of individual's that are familiar with the questionnaire methods and the problem at hand. The 8 persons consulted were experts in the field of HIV/AIDS in addition to possessing vast research experience. They also represented different approaches and were from different organisations. As they represented various race and language groups, any bias reflected in the selection or wording of the questionnaire was omitted. Every questionnaire benefited from forthright criticism due to diversity of values and social outlooks. In addition the questionnaire was scrutinised for technical defects, apart from biases and blind spots due to personal values.

The first step of the piloting involved the questionnaire being administered to 3 social work colleagues. This method was a try out of the questionnaire to see how

it worked and whether changes were necessary before the start of the full-scale study. This provided a means of catching and solving unforeseen problems in the administration of the questionnaire such as phrasing, sequence of questions and its duration of completion. The results from this exercise indicated that the questionnaire was ready to be administered to the chosen sample and as there were no changes to be made, further revision was not necessary.

After all the preceding steps were completed the questionnaire was edited by 2 of the experts originally consulted to ensure that every element passed inspection in terms of content, form, sequence of questions, spacing, arrangement and appearance of the material and the spelling out in detail of the procedures for using the questionnaire. The editorial job is directed primarily at making the questionnaire as clear and easy to use as possible. The person finally responsible for the final editing was the researcher's supervisor who ensured that the questionnaire met all the necessary criteria before being mailed to the respondents. The process of drafting the questionnaire to editing the final analysis proved to be very time-consuming and took a period of approximately 6 months.

The questionnaire consisted of 34 questions ranging from the closed/structured to the semi structured, to the completely unstructured. The questionnaire consisted of 26 structured/standardised questions and 8 open/ unstandardised questions. The same questionnaire was presented to all 55 respondents ensuring that uniformity was present.

Scaled questions, which consisted of statements, and questions were used. The rating scale allowed the respondents to indicate the degree to which they agree or disagree with an item. Scaled questions are useful for measuring attitudes as they captured subtle gradations of opinion or perception as indicated by the questionnaire. Some of the scales used were the Likert scale and true-false questions and questions that required a fixed response.

'Open-ended' questions are designed to permit a free response from the subject rather than one limited to stated alternatives. The distinguishing characteristic of open-ended questions is that they raise an issue, but do not provide or suggest any structure for the respondent's reply. The respondent's are given the opportunity to answer in his or her own terms and in her own frames of reference. Fixed alternative questions have the advantages of being simple to administer and quick and relatively inexpensive to analyse. The analysis of responses to open-ended questions is often difficult and expensive. Categories for analysis must be built up and the responses must be coded into one of the categories before they can be tabulated and statistically analysed.

A fixed-alternative question helped to ensure that the answers were given in a frame of reference that was relevant to the purpose of the inquiry and in a form that was usable in the analysis. In certain cases the provision of alternative replies helped to make clear the meaning of the question. This function of clarification may be important not only in relation to words whose meaning may not be generally known but in relation to concepts that may not be familiar to the respondent. A similar function of alternative responses was to make clear the dimension along which answers were sought. More precise wording of open-ended questions might eliminate this difficulty by indicating more clearly which dimension was intended or by asking separately about both. Finally, the closed-ended questions may require the respondents themselves to make judgments about their attitudes rather than leaving this up to the researcher. This may or may not be desirable depending on the nature of the question.

One of the major drawbacks of the closed ended question is that it may force a statement of opinion on an issue about which the respondent does not have any opinion. Many individuals have no clearly formulated or crystallised opinions about many issues. This important characteristic is not likely to be revealed by a closed question. Inclusion of a neutral alternative i.e. 'uncertain' was deliberately omitted so that respondents were compelled to state an opinion.



Closed ended questions were found to be more efficient where the possible alternative replies are known, limited in number and clear-cut. Thus in this questionnaire they were more appropriate regarding extracting factual data such as qualifications, demographic details and position.

Dillman (1972) and Erdos (1970) reported that special care in the design of questionnaires and follow-ups could contribute to high completion rates. The guidelines as stated by Selltiz et al (1976) that the researcher followed included

- 1) The attractiveness and clarity of the questionnaire format.
- 2) The length of the questionnaire.
- 3) The nature of the accompanying letter requesting cooperation
- 4) The ease of filling out the questionnaire and mailing it back.
- 5) The interest of the questions to the respondent.
- 6) The nature of the people to whom the questionnaire is sent.

The high response rate of questionnaires can be attributed to the attractively designed questionnaires that were short, clear, easy to fill out, interesting to the respondent, simple to return, personalised with regard to a covering letter, self-addressed envelopes and the presentation of contents that motivated the respondents to cooperate.

In devising questionnaires, question wording also plays an influencing factor in terms of affecting response rates. The following aspects as highlighted by Stribley et al (1979) served as guidelines for the questionnaire:

- 1) Questions that are insufficiently specific. A common error is to ask a general question when a specific answer is required.
- 2) Simple language. In choosing the language for a questionnaire the population being studied should be kept in mind.
- 3) Ambiguity. Ambiguous questions are to be avoided at all costs as different people understand the question differently. Ambiguity also arises with double-barreled questions.

- 4) Vague words. Vague questions encourage vague answers.
- 5) Leading questions. A leading question is one, which, by its content, structure and wording, loads the respondent in the direction of a certain answer.
- 6) Presuming questions. Questions should not, generally speaking, presume anything about the respondent.
- 7) Personalised questions. It is often necessary to decide whether a question should be asked in a personalised form or not.
- 8) Embarrassing questions. Subjects, which people do not like to discuss in public, present a problem to the questionnaire designer. Respondents are often embarrassed to discuss private matters, to give low prestige answers and to admit to socially unacceptable behavior and attitudes.
- 9) Questions involving memory. Most factual questions to some extent involve the respondent in recalling information. His degree of success in doing this accurately is thus a basic determinant of the quality of the response.
- 10) In this study the researcher did not ask for any information requesting for direct statistics whereby this would be time-consuming for the respondent in view of the high caseloads and time-constraints facing most social workers.

Open-ended questions are called for when the issue is complex, when the relevant dimensions are not known, or when the interest of the research lies in the exploration of a process or of the individual's formulation of an issue. The closed-ended question has the advantage of focusing the respondent's attention on the dimension of the problem in which the investigator is interested, by the same token, it does not provide information about the respondent's own formulation of the issue, the frame of reference in which the respondent perceives it, the factors that are salient, or the motivations that underlie the expressed opinions. When these matters are the focus of interest, open-ended questions are essential. Overall, the combinations of open and closed ended questions proved to be efficient for getting complex information.

### **Process of Data Collection-Mailed Questionnaires**

Questionnaires were mailed to the 55 Directors of child welfare organisations of Kwazulu-Natal together with a covering letter and a self-addressed, stamped envelope. The covering letter served to inform the respondents of the purpose of the research and they were asked to complete the questionnaire and return the completed questionnaire within a specific time period.

Some of the advantages of mailed questionnaires as stated by Goldstein (1989) include:

- 1) Anonymity is provided by the respondent, as he or she does not have to face the interviewer and therefore is freer to respond to questions.
- 2) Less expensive administration is characteristic of the mailed questionnaire.
- 3) Data are collected from a sample that is geographically dispersed as in this research areas included Ladysmith, Richmond, Stanger which would have been time-consuming and expensive if not covered by mailed questionnaires.
- 4) They can be used to gather data far more inexpensively and quickly than interviews.
- 5) Elimination of the problem of interviewer bias as sometimes an interviewer influences a person's response to a question in terms of what he or she is saying, his tone of voice or demeanor.

Some of the disadvantages according to Goldstein (1989) are:

- 1) The researcher has no control over the conditions under which questionnaires are completed in people's private homes, and does not know who actually completed the questionnaire, or whether they treated the task seriously or not.
- 2) Respondents cannot ask for clarification if they do not understand some of the questions.

- 3) The main drawback is the high non-response rate that may bias the sample.
- 4) Mailed questionnaires require a minimal degree of literacy and facility in English that some respondents do not possess. Substantial non-response is likely with such people.
- 5) Responses cannot be considered independent as the respondent can read through the entire questionnaire before completing it.
- 6) All mailed questionnaires face the problem of non-response bias.

In ensuring a high response rate the researcher adapted the guidelines as suggested by Dillman et al (1994). The first contact with the respondents was via telephone whereby the researcher gave a brief overview of the study in terms of the purpose and motivated them to respond. The first mail-out was sent 2 weeks later to all 55 organisations. The initial response resulted in 22 questionnaires. A follow-up resulted in another 10 responses. A third follow-up resulted in the receipt of the balance of responses. All follow-up letters included a restatement of the points in the original cover letter with an additional appeal for their cooperation, the original questionnaire and a self-addressed stamped envelope. This process lasted a period of between 4-5 months.

According to Goyder (1985) follow-ups are one of the most important procedures affecting response rates. As evident in the study a substantial percentage of non-respondents to the initial mailing responded to the follow up letters. With the two follow-ups increases of approximately 40% increases over the initial return was achieved.

### **Process of Data Collection: Interviewing**

"Interviewing is the predominant mode of data or information collection in qualitative research. All interviews are interactional events and interviews are

deeply and unavoidably implicated in creating meanings that ostensibly reside within participants." Manning cited in Holstein and Gubruim (1995:3).

Kvale, cited in Sewell (2001:1), defines qualitative interviews as "attempts to understand the world from the participants point of view, to unfold the meaning of people's and to uncover their lived world prior to scientific explanation. "

The researcher followed the techniques as outlined by Sidman (1998: 63-77) to ensure effective interviewing strategies. The researcher allowed for 90% talking from the participant, clear and brief questions were asked, single questions were considered including truly open-ended questions, sensitive questions were avoided, experience and behaviour questions were asked before asking opinion or feeling questions. In addition, sequence questions were utilised from the specific to the broad to the narrow and leading questions were avoided. Also, for maximum and successful responses communication techniques utilised are vital for interviewing. Sacks, quoted in Holstein and Gubruim (1995:46,47) cited the following important techniques, which were utilised by the researcher. this included, minimal verbal responses, paraphrasing, clarification, reflection, encouragement and reflections.

For the purposes of this study, the semi-structured one-to-one-interview was used as opposed to the structured or unstructured interview. In general, researchers use semi-structured interviews to gain a detailed picture of participant's beliefs or account of a particular topic. This method gives the researcher and participant more flexibility. The researcher is able to follow up particular interesting avenues that emerge in the interview and the participant is able to give a fuller picture. However, semi-structured interviews are especially suitable where one is particularly interested in complexity or process where an issue is controversial or personal. With semi-structured interviews the researcher had a set of pre-determined questions in an interview schedule, but the interview was guided by the schedule rather than dictated by it. The participant shares more closely in the

direction the interview takes and he or she can introduce an issue the researcher had not thought of. In this relationship, the participant can be perceived as the expert on the subject and should therefore be allowed maximum opportunity to tell his or her story. Smith, et al (1995:9-26).

A questionnaire written to guide interviews is called an interview schedule or guide. This provided the researcher with a set of pre-determined questions that could be used as an appropriate instrument to engage the participation and designate the narrative terrain (Holstein and Grubium, 1995:76). Producing the schedule beforehand forced the researcher to think explicitly about what she hoped the interview might cover. It forces the researcher to think of difficulties that might be encountered g. in terms of question wording or sensitive areas. Hutchinson and Webb, cited in Morse (1991:311) point out those generating useful questions with appropriate content and structure takes time and thought.

Semi-structured interviews generally last for a considerable amount of time and can become intense and involved, depending on the particular topic. If the researcher has learnt the schedule in advance, then he will be able to concentrate on what the participant is saying during the interview and also occasionally monitor the coverage of the scheduled topic (Smith et al, 1995:2-26).

The researcher obtained permission to tape record the interviews from the participants. According to Smith et al (1995:17), this allows a much fuller record than notes during the interview. It also means that the researcher can concentrate on how the interview is proceeding and where to go next. Careful attention was given to the placement of the tape recorder so as not to unnerve the participant. In accordance with Field and Morse's (1994:79-82), recommendations the researcher, jotted the impressions immediately after the interviews were conducted. This assisted the researcher to remember and explore the detailed processes of the interview and to minimise the loss of data. The field notes

included both the empirical observations and interpretations, both of which were kept distinct.

As advised according to Delport (2002:305), it is poor practice to 'stack' interviews and then to try and synthesise all the tapes. The researcher transcribed and analysed the interviews while they were still fresh.

The strengths of one to one interviews include that they are a very useful way of getting large amounts of data quickly and are an especially effective way of obtaining depth in data. However, interviews also have limitations. They involve personal interaction and co-operation is therefore essential. Participants may be unwilling to share and the researcher may ask questions that do not evoke the desired responses from the participants. Furthermore the responses could be misconstrued or even, at times, untruthful.

## **Sampling**

Lane, cited in Delport (2002:199) defines a sample as "comprising the elements of the population considered for actual inclusion of the study." In other words, a sample is a selection of elements (members or units) from a population; it is used to make statements about the entire population. In this example, the target group of 55 Directors was the sample selected. This sample can be regarded as a perfect representation of a population as it has all the relevant features of the population.

Two broad types of sampling methods are probability and non-probability sampling (Babbie et al, 1998). In order to distinguish between the two types of sampling a brief description of probability and non-probability sample will be given. Dejong et al (1998: 128) states the following regarding probability sampling. "This method ensures that each element has an equal chance of being included. In more elaborate versions, the researcher takes advantage of knowledge about the

population to select elements with differences and probabilities. Furthermore probability sampling enables us to calculate sampling error which is an estimate of the extent to which the values of the sample differ from those of the population from which it was drawn." Generally this method is the preferred method. However, probability samples are not required or even appropriate for all studies. Some research situations call for nonprobability samples, in which the investigator does not know the probability of each population element's being included in the sample. Although non-probability samples can be very useful, the researcher was aware of their limitations as outlined by Dejong (1998:140):

- ⌘ Without the use of probability in the selection of elements for the sample, no real claim of representativeness can be made. There is simply no way of knowing precisely what population if any, a non-probability sample represents. This question of representativeness greatly limits the ability to generalise findings beyond the level of the sample cases.
- ⌘ A second limitation is that the degree of sampling error remains unknown and unknowable. With no clear population being represented by the sample, there is nothing with which to compare it. The lack of the probability in the selection of cases means that techniques employed for estimating sampling error with probability samples are not appropriate. This also means that the techniques for estimating sample size are also not applicable to nonprobability samples. The only factor impacting on sample size for nonprobability samples is that sufficient cases be selected to allow the types of data analysis that is planned.
- ⌘ A final limitation of nonprobability samples involves statistical tests of significance. These commonly used statistics indicate to the researcher whether relationships found in sample data are sufficiently strong to be generalisable to the whole population

Despite these limitations, nonprobability samples have their uses, some of which include the goal of the research to see whether there is a relationship between



independent and dependent variables and when generalising sample results to a population, nonprobability sampling must be used with care. As many research situations preclude the use of probability sampling, especially when it is impossible to create lists of elements to be sampled. In this study, the non-probability convenience sampling method was used, as this was the best and most feasible method for the study design and the sample used had all the criteria necessary for sampling and the number was sufficient to make generalisations.

Convenience sampling involves taking whichever elements are readily available to the researcher (Dejong et al, 1998). The limitation on generalisability, however, seriously reduces the utility of findings based on available samples. Availability /convenience sampling is probably one of the more common forms of sampling used in human service research, both because it is less expensive than many other methods and because it is often impossible to develop an exhaustive sampling frame. Available samples, though less desirable, make it possible for scientific investigation to move forward in those cases where probability sampling is impossible.

Convenience sampling was used for the mailed questionnaires and is justified in this research in view of representativeness. According to Hagedorn et al (1976), inference from samples to populations is a matter of the confidence that can be placed in the representativeness of the sample. A sample is representative to the degree to which it reflects the characteristics of a population, which is relevant in this case. To be adequate, a sample must be of sufficient size to allow the researcher to have confidence according to statistical techniques in the inference as was indicated in the study.

For the qualitative approach, purposive sampling was used. This type of sampling is based entirely on the judgment of the researcher, in that a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population. (Singleton cited in Delpont 2002:207).

In purposive sampling a particular case is chosen because it illustrates some feature or process that is of interest for a particular study, though this does not simply imply any case we happen to choose (Silverman, 2000:104). In purposive sampling the researcher must first think critically about the parameters of the population and then choose the sample case accordingly. Clear identification and formulation of criteria for the selection of respondents are therefore of cardinal importance. Creswell (1998: 118) comments as follows in this regard: “ The purposeful selection of participants represents a key decision point in a qualitative study. Researchers designing qualitative studies need clear criteria in mind and need to provide rationales for their decisions.” The search for data must be guided by processes that will provide rich detail to maximise the range of specific information that can be obtained from about that context (Erlandson et al, 1993:33).

### **Data Analysis**

According to Dejong et al (1998), data analysis is what unlocks the information hidden in the raw data and transforms it into something useful and meaningful. During data analysis, you learn whether your ideas are confirmed and refuted by empirical reality.

According to Kerlinger (1985) as cited by Reid et al (1989:244), “data analysis is the categorising, ordering, manipulation and summarising of data to obtain answers to research questions.”

The approach to analysis differs depending on the research questions, the design of the study and the type of data collected. The major difference is between qualitative and quantitative studies.

## **Quantitative Data Analysis**

Quantitative data in social work research can be analysed by hand or by computer. For this study, statistical procedures in the form of computers were used to analyse the quantitative data. Computers can perform mathematical calculation very quickly and reduce the errors that are introduced by manual calculations (Gilbert et al: 2000:22). The most widely used suite of programmes for statistical analysis in the social sciences is the Statistical Package for the Social Sciences (SPSS) (Caputi, 2001:126). The SPSS is a comprehensive tool for managing, analysing and displaying data. A broad range of statistical analysis and data modification tasks is accomplished with a minimal understanding of computers especially as the researcher had minimal knowledge of this programme (Cramer, 1995:17).

There are two steps in the use of the SPSS programme (Caputi: 2001:126), which the researcher used. The first is constructing a data file and the second is writing a SPSS programme to perform the statistical analysis of the data. When the SPSS programme is executed in conjunction with the data file, the analysis will be the output.

The data file consists of a series of lines of data. In an SPSS data file, the data for each subject was formatted in columns across the line. The data file itself consists only of data needed for the analysis. It does not include the names of the actual variables or any other information.

Computer analysis requires that all data be coded numerically. Even though a subjects responses were coded as 'yes' or 'no', these were coded as numbers in the computer e.g. if the subject said 'yes' this was coded as '1' and 'no' was coded as '2'. The same principle applied to all variables in the study.

According to Besag, et al (1985), different procedures are appropriate and logical for different types of data. The nominal data are the lowest level of data. They cannot be subjected to arithmetic computations or ordered and we can merely categorise and describe. The ordinal level of data allowed the researcher to order the data. They are stronger, more informative and sensitive than nominal data. Here, one category of variable is bigger, better, smarter or larger, but one does not know how much bigger, better or larger. There is an underlying continuum from minimum to maximum, but we cannot accurately measure the intervals. Ordinal-level data are data where the order of magnitude is known but the intervals are not.

In terms of the data preparation, the raw data was converted into numerical equivalents for the purposes of quantitative analysis and possible statistical testing. The researcher abided by the 4 stages as outlined by Baker (1988).

- ⌘ In the first stage, the raw data was coded into numbers and this is referred as the coding stage. Durheim (1999) referred to this stage as the preparatory stage.
- ⌘ The second stage is preparing the coded information to be transferred from written form to a form, which can be accepted by a computer i.e. a machine –readable format. This is referred to as the transfer stage.
- ⌘ The third stage involves the actual process of entering the coded data into the computer and is referred to as the computer entry stage.
- ⌘ The fourth stage involves cleaning the data once they are on the computer.

Once the data have been coded, they must be transferred to some medium that will allow them to be entered into a computer.

Coding the data involves assimilating the raw data into a form, which can be quantified for analysis. The principles guiding the coding system as stated by Baker (1988) was applied.

- ⌘ The first principle is that coding must resolve issues of definition and ambiguity so that the codes can be applied consistently. Of importance is that the meaning of the concept must be maintained.
- ⌘ The second principle is to preserve as much as possible of the actual meaning of the responses and of the variation presented in the data. In this research all the data were coded and no information was discarded to avoid collapsing of categories in the course of coding. Instead, reducing and recoding the data was left for the next stage of the process. This procedure allowed the researcher to have more options in terms of the use of many variables as she proceeded with the analysis.
- ⌘ In terms of the third principle, which states that the coding system must be planned at the time of the design of the instrument, was not utilized by the researcher. The reasons for this is that some questions were broken down into subsections so that when a respondent viewed the number of questions it did not seem like there were too many as this could affect the response rate. The researcher chose to recode the questionnaire for analysis purposes by compiling a master copy of categories, which was used as a reference when assigning codes to the questions. This procedure also simplified and speeded the data transfer procedure itself
- ⌘ The coding system also assisted to reduce the number of times that the data was handled, as the more times data are handled the more times are they prone to mistakes being added. For this reason, coding systems should be clear and precise.

As every variable in the study was given a variable name, every respondent was given a case number, which was recorded by the researcher on top of each questionnaire. In this case the returned completed questionnaires ranged from 0001 to 00055. These were then entered into the computer as a variable in the study. The primary reasons for doing this was to help keep the responses systematic and to make checking for errors easier.

The type of response categories utilised determined the types of coding strategies. The first type involved attitudinal questions, which provided a set of ordinal scale responses. This was the likert scale question. This is the the most widely used form of scaling that sets up ordinal categories for degrees of agreement including the 5 levels of strongly agree, agree, uncertain, disagree and strongly disagree. The response categories are attached to a set of statements. Assuming that the responses to each statement are equivalent, the researcher assigned scores from 1 to 4 as the researcher omitted the response category of uncertain. One of the reasons for this is that in view of the high caseloads and time constraints it was felt that the respondents would resort to the 'uncertain' category to complete the questionnaire. The second type offered answers, which were dichotomies i.e. yes, and no responses. The third type offered answers that required specific responses and the fourth type were open-ended questions which were coded separately and utilised the process of categorizing and coding in terms of the qualitative approach which will be discussed later.

According to Dejong et al (1998) when coding categories are being established 2 general rules should be followed. First, the coding categories should be mutually exclusive i.e. a given observation is coded into one and only one category for each variable e.g. the universal practice of categorising people by sex as either male or female exemplifies mutually exclusive categories. Secondly, coding categories should be exhaustive which means that a coding category exists for every possible observation that was made.

The final stage in data preparation is cleaning the data. Coding and entering data are labour-intensive and boring tasks and errors can easily occur. After all the trouble the researcher has taken in producing valid measures, errors at this stage must be eliminated. If the data set contains errors, the results of the study will be invalid. Cleaning the data involves checking the data set for errors and correcting these errors. After coding the researcher selected a random sample of 15% of the cases. There were no errors found and thus the data was ready for analysis. Once

the researcher had a clean, accurate database in a machine-readable format, the data was analysed statistically.

According to Grove et al (1991), "Quantitative research can be defined as a formal objective, systematic process in which numerical data are utilised to obtain information about the world."

The above definition bears relevance for analysis. Quantitative research aims to determine the relationship between one thing i.e. an independent variable and another i.e. a dependent or outcome variable in a population. As this was a descriptive study it establishes associations between variability and not causality. In addition, it provides quantitative indicators of what is common or typical about a variable, how much diversity or difference there is in the variable and how values on one variable are associated with values on one or more other variables. Quantitative is about quantifying relationships between variables. The relationships were expressed by using statistics such as correlations, frequencies and graphical displays such as bar graphs. An important consideration according to Dejong et al (1998) appropriate statistics should be used to determine the goal of the statistic. Each statistical technique performs a particular function revealing certain information about the data. A clear conception of the analytical goals of the data analysis is a prerequisite for selecting the best statistic formulation for achieving specific goals. In this case the statistical techniques utilised had the goal of descriptive analysis. Another consideration in choosing an appropriate statistic is the number of variables to be analysed. In this study univariate and bivariate variables were predominantly used.

Some of the techniques used in the study will be described. Correlational research refers to studies in which the purpose is to discover relationships between variables through the use of correlational statistics ( $r$ ). This technique permits the researcher to analyse the relationships among a large number of variables in a single study. The correlation coefficient provides a measure of degree and

direction of the relationship. It is important to consider the variables used in performing correlations. Correlation is only appropriate when variables are coded and that the numbers assigned are meaningful. This means that a high score on the variable in the correlation must mean something. When correlations are generated, the statistic or correlation value is the value of 'r' and it is associated with the 'p' value. The 'p' value less than 0.05 are considered significant. In interpreting correlations, it is important to take into consideration the direction of '+' or '-' associated with the 'r' value. If the 'r' value of the correlation between two variables is positive, it means that as the value for one variable increases, so does the value for the other variable. If the 'r' value for the correlations between two variables is negative, it means that as the value for one variable increases, the value for the other variable decreases (Gilbert et al: 2000:165-176).

Another technique of analysis is the graphic display of data statistics in the form of graphs. The visual impact of a graph can help identify and summarize patterns in data that might not be detected as readily as perusing frequency distribution tables. A distinguishing feature of the bar graph is the space between the bars. These spaces illustrate that the categories of the variable being represented are separate or discrete. Nominal and ordinal variables are by definition discrete variables so bar graphs are especially useful for these levels of data (Caputi 2001:118-121; Gilbert et al: 2000:80-84).

Central tendency is an index of the most representative score in a distribution. There are several different measures of central tendency. The first one is the average or mean. Summing all the scores in the distribution and then dividing that total by the number of scores find the mean. The second index of central tendency is the mode. This is the most frequently occurring score in a distribution to compute the mode. We count the number of times each score occurs in the distribution and the score that occurs most becomes the modal value. If they're two different scores occur most frequently, then we call the distribution as having 2 modes. The third index of central tendency is the median. When the scores



have been arranged in hierarchical order, the median is the score that precisely divides the distribution in half. Therefore, computing the median consists of rank-ordering all scores from lowest to highest and then identifying the score at the 50<sup>th</sup> percentile (Cramer: 1995:82-85; Gilbert et al: 2000:91-102).

Another technique, the frequency distribution allows you to count the number of occurrences that fall into each category of each variable. Sometimes it is more interesting to examine relative rather than actual frequency of an interval Caputi et al (2001:114). The relative frequency of an interval is obtained by dividing the frequency of the interval by the total number of observations. This fraction can also be reported as a percentage. "By frequency is simply meant the number of times that something occurs"(Cramer: 1995:76). This method is useful if you wish to compare either parts of the same distribution or distribution from two or more groups.

### **Qualitative Data Analysis**

According to Cresswell (1994), the process of qualitative data analysis involves making sense out of text and image data. It involves preparing the data for analysis, conducting different analysis, moving deeper and deeper into understanding the data, representing the data and making an interpretation of the larger meaning of the data.

According to Richards et al (1995) generally, the volume of data that qualitative researchers must manage is enormous. Researchers tell stories of 'drowning in data ' while the process of analysis is ongoing. However, in a well-designed and well-conducted study, data are not over collected and they are well managed. This is indicative of this study whereby only 6 participants were incorporated as part of interviewing process, which added to rich in-depth data necessary to enhance the overall goal of the research.

The researcher followed certain steps in qualitative research.

- ⊗ Durrheim et al (1999) and Cresswell (2003) step of familiarisation and immersion were used. According to them, data gathering is not just a mindless technical exercise, but involves development of ideas about the phenomenon being studied, even as the researcher was formulating the questions and collected the data. Once the data was received, a preliminary understanding of the meaning of data was achieved. Once all the data was received the researcher immersed herself in the data i.e. with the content of the questionnaires. The ideas formulated by Tesch (1990: 142-145) also reiterate this aspect. By reading the transcriptions carefully, a sense of the whole was achieved and various ideas were jotted down as they came to mind in addition, some key and important ideas were highlighted.
- ⊗ The next step involved transforming the data which is an idea explored by Richards et al (1995). Whatever the approach, data requires coding into a manageable format in order that it is analysed so that conclusions can be represented. Each research event is transformed from an actual happening to a form that can be handled and manipulated in the process of analysis. Ideally this process keeps the data as close to the actual events as possible.

“Any researcher who wishes to become proficient at doing qualitative analysis must learn to code well and easily. The excellence of the research rests in large part on the excellence of the coding” (Strauss: 27).

There are many ways of coding and many purposes for coding activities across the different qualitative methods. They all share the goal of getting from unstructured and messy data to ideas about what is going on in the data. All coding techniques have the purpose of allowing the researcher to simplify and focus on some specific characteristics of the data.

Dey, cited in Blaikie (2000: 240) has formulated coding as a circular spiral process involving three activities i.e. describing, classifying a connecting.

The first step is to produce 'thick' or 'thorough descriptions of the phenomenon being studied. (Geertz, 1973: Denzin, 1978). Blaikie (2000) refers to this as 'open coding.' 'Thin' description merely states 'facts' while 'thick' description includes the context of the action, the intensions of the social action and the processes through which social action and interacting are sustained and or changed. Rallis et al (1998: 171) referred to this process as organizing the material into 'chunks'.

The second stage revolves around classification and Dey (1993) has dealt with the activities referred to as 'open' and 'axial' coding of grounded theory. In the same way he has argued that classifying data is an integral part of the analysis and without this there is no way of knowing what is being analysed. Classification is achieved by creating categories, assigning categories to the data and splitting and slicing categories. According to Corbin et al (1990:63) " this stage involves breaking the data down into categories and sub-categories, i.e. taking apart an observation, a sentence, a paragraph and giving each discrete incident, idea or event, a name, something that stands for or represents a phenomenon. This is a process of breaking down, examining, comparing, conceptualizing and categorising data."

The third part of the process is making connections between categories. The aim is to discover regularities, variations and similarities in the data. According to Strauss (1999), the coding used to find relationships between these categories and sub categories, thus puts the data back together in a new way. This is referred to as a 'coding paradigm' which involves thinking about possible causal conditions, contexts, intervening conditions, action and interaction strategies used to respond to a phenomenon in its context, and the possible consequences of action or interaction not occurring. A core category is then selected and a descriptive narrative constructed about it.

The researcher elaborated and developed coding in terms of topic coding. Codes, at their simplest are just labels and when one assigns labels the focus becomes analytical. (Richards et al, 1995). Topic coding is the most common and most challenging type of coding done in qualitative research. It s a very analytic activity and entails creating a category or recognises one from earlier, reflection on where it belongs among the researchers growing ideas and reflecting on the data one is referring to and on how they fit with the other data coded there. (Richard et al, 1995).

Topic coding was used in the first stage of the analysis as it assisted in obtaining deeper and insightful meanings of data and because of its analytical technique assisted the researcher in developing themes, which emerged from the categories.

The development of themes occurred during the processes already discussed. However, themes are used to mean something more pervasive than a topic or category. A theme runs right through the data and is not necessarily confined too specific segments of text. Once the researcher identified a theme she was more likely to see segments of the text that were pertinent to that text. The themes were incorporated into the research questions that appeared as major findings.

For analytic plurality the analysis of the quantitative methods were combined with that of qualitative methods whereby themes in the form of research questions were validated by statistical formulations such as frequencies, correlations, graphs and measures of central tendencies.

### **Validity and Reliability**

The quality of research depends not only on the adequacy of the research design but also on the quality of the measurement procedures employed. To be useful,

data-collection techniques and the rules for using the data must produce information that is not only relevant but also correct. Two crucial aspects of correctness are reliability i.e. the extent to which measures can give consistent results and validity i.e. the extent to which they correspond to the 'true' position for the person or object on the characteristic being measured (Black, 2002).

Bostwick and Kyte (1981:104-105) described validity as doing what it is intended to do and measuring what it is suppose to measure. There are 2 types of validity i.e. internal and external validity.

The external validity is overwhelmingly important as the researchers will very rarely want to restrict findings to the study sample, and will usually select research participants from particular populations, thereby declaring an intension to generalise. Therefore external validity of research refers to the generalisability of findings from the study (Cresswell, 2003).

The essential question that must be asked is whether the study has used any techniques that attempt to ensure generalisability. This can be spelled out in terms of two typical aspects of the design (Durrheim et al, 1999).

- 1) In this research although the convenience and purposive sampling techniques were used which is not generally recommended for generalisability it was an appropriate sampling technique to ensure that research participants were representative of the target group. In addition child welfare organisations in KwaZulu-Natal are governed by the same policies and legislature as other regions and provinces, the findings of this research can be generalised to other regions and provinces. The sampling methods are crucial to the external validity of the research.
- 2) Did the researcher take the measures representative of the class of possible measures?

The validity of a measuring instrument reflects the extent to which one measures what one thinks one is measuring. There are 3 main types of validity of which content validity is applicable for this research.

Internal validity addresses the set of measurement instruments and the measurement methods used in the research. The content included in the instrument was relevant to the concept we are trying to measure as knowledge was measured by consultation with various experts in the field who had an in-depth knowledge of the concept under study. The content, language and format of the questionnaire was corrected and revised until a final precisioned questionnaire was devised. In addition a pilot study was conducted whereby 3 social workers were given the questionnaire as a pre-test before it was administered to the actual sample selected.

Another method that the researcher utilized to enhance the validity was to conduct a comprehensive literature review of the concepts she wanted to measure, to ensure that she was aware of all the relevant components and dimensions (Reamer, 1998).

Another aspect that can affect validity is the possible source of errors (Reamer, 1998). It is possible that the data collected will contain some errors. This happens when we rely on human beings to collect and record information. Aspects such as faulty memory, people providing false information deliberately, people giving socially desirable responses to questions in order to cast them in an unrealistically positive light because they want to protect or preserve their self-image or because they want to be viewed favorably by others (Marlow, 1964). This was unlikely in terms of the responses of child welfare organisations as most of the responses indicated that they were experiencing serious challenges in terms of their responses to HIV/AIDS.

Combining measures has enriched the study and has helped to ensure that the researcher was tapping a maximum number of dimensions of the phenomenon under study. The correct methods were used and the process of checking and rechecking were utilised. The triangulated method helps to enhance the validity of the findings.

The use of quantitative methods included statistical tests, which enhanced the accuracy of the findings.

The central consideration concerning the process of data collection is that of reliability. Reliability has been defined as the accuracy or precision of an instrument, as the degree of consistency or agreement between two independently derived sets of scores, and as the extent which independent administrations of the same instrument yield the same or similar results under comparable conditions. Synonyms for reliability are dependability, stability, consistency, predictability, accuracy, reproducibility, repeatability and generalisability( Bostwick and Kyte cited in Delport (2002:168).

There are two major ways to assess the instrument's reliability:

- ⌘ Assessing sources of error
- ⌘ Assessing the degree to which the instrument's reliability has actually been tested.

When assessing the reliability of an instrument, you need to determine whether there is evidence of certain sources of error. There are 4 main types of error, which is: unclear definition of variables, use of retrospective information, variations in the conditions for collecting the data and the structure of the instrument.

Variables can be difficult to define because many social work terms tend to be vague. If a variable is not clearly operationalised and defined, its measurement lacks reliability. The possible outcome can be interpreted differently by different

social workers. The wording of questions in questionnaires often creates problems with unclear definitions of variables. A question might be phrased in such a way that 2 individuals interpret it differently and provide 2 different answers, even though the actual behavior they are supporting is the same. Retrospective information was not used, as the researcher did not allow for subject recall thus there could not have been room for distortion.

In terms of the mailed questionnaires, lack of control over the conditions under which they were administered could have resulted in low reliability. Certain aspects of the data collection instrument were open-ended questions, thus this could present reliability problems.

### **Ethical Considerations**

Social workers increasingly realise that the recognition and handling of ethical aspects are imperative if successful practice and research is the goal. Anyone involved in research needs to be aware of the general agreement about what is proper and improper in scientific research (Babbie, 2001:470).

"Ethics is the study of what is proper and improper behavior, of moral duty and obligation. Moral principles can be grounded in philosophy, theology or both. For social researchers, ethics involves the responsibilities that researchers bear toward those who participate in research, those who sponsor the research and those who are the potential benefits of the research" (Dejong et al, 1998:45).

Babbie (1998) identified 5 basic principles in handling ethical concerns. These were considered during the planning and implementation of the research project.

Voluntary participation was used. This principle is important because social research often represents an intrusion into people's lives and often requires that



people reveal personal information about themselves. Social research often requires that people reveal such information to strangers i.e. the researchers. Although other professionals such as physicians and lawyers also require such information and are strangers to the person, the social researcher cannot make the claim that revealing information is required to serve the personal interests of the respondent. However, social scientists argue that involvement in research may ultimately help all humanity. The next principle involves protecting the anonymity and confidentiality of research subjects. A respondent is anonymous when the researcher cannot connect a given response with a given respondent. The researcher is able to identify a given person's responses but promises not to reveal this identity. Using identification numbers instead of names enhanced confidentiality. Another important principle as stated by Durheim et al (1999) is autonomy. This principle requires the researcher to respect the autonomy of all persons participating in the research.

The researcher's identity can also be an ethical problem. In this study the researcher identified herself as a researcher and the overall purpose of the study was explained to avoid deception.

Ethical concerns enter in the analysis and reporting of data. Ethical obligations to colleagues dictate accurate reporting of the shortcomings and negative findings in a study. Also, social scientists should not identify accidental findings as the product of careful hypothesising and theorising.

## **Conclusion**

In this chapter the researcher examined the methodology that was used in the study. The main aim of this section was to outline from where and how the data was collected and how it was analysed. It dealt with the research design,

decisions about the sources, types and forms of data needed to answer the research questions and the methods of collecting, reducing and analysing data.

Yin (1984) suggests that perhaps the most important way of enhancing reliability is the use of triangulation. Multiple methods of data collection were used to improve validity and reliability. Mailed questionnaires combined with personal interviews were central to the study and were implemented to increase the accuracy of data collection, analysis and findings, which are discussed in detail in the next chapter.

# PART FOUR

## **PART FOUR: ANALYSIS AND DISCUSSION**

### **Introduction to Chapter Six and Seven**

In view of the extensive and intensive range of data obtained, the complex issues ascertained and the two broad themes that emerged from the findings, this part is divided into two chapters. Chapter Six focuses on related factors attributed to burnout and stress with particular relevance to staff issues and vital support structures that play a strong role for child welfare organisations, whilst Chapter Seven discusses the important findings pertaining to child welfare's adoption of the principles of the developmental paradigm.

In these chapters, the researcher provides the findings from the data obtained from the questionnaires and the interviews conducted. A combination of data from the audio recordings of the interviews and data from the self-administered mailed schedule is also presented. The responses of the 43 participants from the mailed questionnaires, together with data from the 5 interviews are discussed in terms of the triangulated paradigm. The data from the structured questionnaires are quantitatively analysed by utilising categories and statistical calculations. This is combined with the themes and categories that emerged from the semi-structured interviews, which formed the basis of the qualitative analysis.

The important sample characteristics as obtained from the results is summarised as follows:

- 1) The quantitative study comprised of a sample group consisting of 40 social work professionals and 4 volunteers. Specifically, the professionals included 5 Directors, 1 Deputy Director, 1 Senior Manager, 10 Managers and 23 social workers.
- 2) With regard to the qualifications, 1 social worker possessed a doctorate degree in social work, 3 possessed the master's degree, 25 possessed the

honours degree, 10 the basic social work degree and 4 possessed qualifications other than social work. These individuals were involved with the organisations on a voluntary basis.

3) The years of experience indicated that 27 individuals have between 7-10 years and more experience, 3 individuals having between 4-6 years, 4 individuals between 1-3 years and 5 individuals between 0-1 year. Majority of the respondents reflected that they occupied the same position between 0-5 years, a lesser number between 6-10 years and 3 respondents indicated that they were in the same position for 16 years and longer. The qualitative sample representative from the four child welfare organisations comprised of 3 senior managers, 2 managers and 1 HIV/AIDS co-coordinator.

Demographic areas were almost equally represented in terms of urban and rural areas as 23 were from rural areas and 20 were from urban areas, of which 4 were also servicing rural areas.

## **Chapter Six**

### **ANALYSIS AND DISCUSSION: BURNOUT AND STRESS**

#### **Introduction**

The analysis of the data identified burnout and stress among social workers within child welfare organisations as a strong overall negative factor in coping with their workloads and rendering services to their clients. Fredenberger (1974) and Maslach (1976) refer to this phenomenon as a kind of stress response experienced by those working in the helping professions such as social work. Burnout refers to a state of physical, emotional and mental exhaustion resulting from involvement with people in emotionally demanding situations. The overall responses from the questionnaires and interviews are summarised according the following headings.

#### **Overview of findings**

##### **Burnout and Stress**

The study found that 77.3% of the respondents, an overwhelming majority, indicated that social workers at the organisations are suffering from burnout and stress as illustrated by the following table.

**TABLE 1: Social workers suffer from burnout and stress in our agency**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	9	20.5	20.9	20.9
	Yes	34	77.3	79.1	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

The frustrations supporting burnout and stress is aptly quoted by the following respondents: "Our services are broad and varied and aims toward focusing on individuals, children, youth, women, families and the community at large. Some of the many functions of the organisation include: to assess and address the social problems of the clientele, to recruit suitable foster and adoptive parents, to ensure the care and custody of orphans, abandoned children and children whose natural parents consented to their adoption, to reunify children with their families, to ensure the protection of abused children, to empower and stabilise the lives of grant receiving families, to develop leadership skills of women, to screen and train volunteers to provide supportive services to victims of domestic violence, to provide material relief to destitute families, to address the behaviour problems of children, to create job opportunities through skills training, to provide information on child abuse, child protection and life skills, to educate parents on their roles and responsibilities and to educate individuals on issues relating to HIV/AIDS, gender, family violence, teenage sexuality and family preservation to promote positive living. The nature, functioning, extent and numerous types of problems social workers have to deal with are too much to bear and stress is unavoidable."

Furthermore, social workers are at risk for burnout when the client presents with problems in which the chronicity, complexity or acuity of the clients' needs are beyond the resources of the social worker (Gillespie, 1987:7). This is substantiated by one respondent: "A challenge specific to our area included the recent closure of a large clothing company in this area, which left hundreds of

people unemployed, and their families in dire circumstances. This places further demands on our already limited resources.”

According to Maslach (1982), the constant expenditure of energy on behalf of others creates a pattern of emotional overload that results in emotional and physical exhaustion of the care provider. Thus the care provider is no longer able to maintain the involvement expected in a helping relationship.

The following extracts from the respondents in the study support this statement.

“Our caseloads are extremely high. Besides the statutory work, we are getting lots of children that are displaying behaviour problems...challenging behaviour...our energies are actually absorbed in removals for example where families cannot cope...so we have to remove those children...what is the solution... I don't know...where do we place them? and because of the high caseload...because the child has been placed in foster care...the social worker has no time to work with the child, the problems actually worsen...then the granny or the caregiver are at their wits end...the problem gets out of hand and the families just want us to remove the children...whether its good or bad for the child...but we have no choice...because the resources are inadequate...we are placing children wherever there is a vacancy, not because there is a particular programme within the children's home or whether it is in the best interests of the child. Our priority is to find a vacancy and just place the child...and children's homes are damn fussy as well...they want perfect children...how can that be because if the children are perfect there would be no need to remove them...so it makes it very difficult. Even when the child is placed at the children's Home, the minute there is some problem, they want the child out...all of us are grappling with this...and there is no solution...it is so damn frustrating at times...”

Another respondent states:” Staff turnover.... lack of personnel.... no Director...I think the inability for us to fill posts. We could deal with turnover, but our problem is beyond that. In our organisation we don't even have people to be turned over.



We have double the problem. For me that's a bigger challenge because there is no continuity of services...I can just imagine the negative impact on clients...even having loads that lie with no intervention as staff have to look at cases that are in crisis...and there is no time for reaching the other clients."

Increasing concern has been voiced by respondents regarding job related stress in social work as the very nature of social work activity i.e. the problems that social workers must confront, the limitations and knowledge of professional ability and the structure of the social work profession all converge to produce a job with inherent stresses.

This is also related to turnover, which affects child welfare organisations drastically. The frustrations as expressed by the interviewees are as follows: "10 years ago the complement of staff could have been 25 or 30...and with the increasing caseloads, the number of staff are drastically lower.... its clear how this impacts on service delivery."

The deep-seated frustrations regarding quantity of workload is supported by Gillespie (1981) who indicated that caseload size is the most frequently identified organisational variable associated with burnout. This is captured by the following detailed extracts from the respondents. "In one of the areas we service, we have 2 posts from the Department of Welfare...but 1 of the posts for a particular area is being used for the other area, which is a massive township. In this sub-office we are sitting with a backlog of cases...clients have come as early as 2000...all we have done is taken them from intake level and that is where it has stopped...workers have resigned...those files are just sitting...we have a backlog of 250 cases. ...we need to do screening...do investigations...open and close enquiries...then we have a backlog of enquiries that have been opened at court and they are at a standstill...we have not been able to finalise...due to turnover and to the specific requirements of that court...its unique functioning compared to other courts. Their requirements are very different. Also with customary law

playing a big role...various documents are required...affidavits are necessary...which is often very difficult to obtain. If there is no proof of the death of the parents, the court refuses to finalise the enquiry even though an affidavit was obtained from the hospital. We have outstanding cases of 2 or 3 years that have not been finalised...then also last year we were getting subpoenas...either the managers or the social workers...we had to adjourn matters...we are sitting with such a huge backlog, its hard to cope with 3 social workers and 2 auxiliary workers...we are going 'cuckoo'...we actually need a complement of 15 or 20 social workers to render services in that area. This hinders services drastically. There is a lot of things still hanging...the backlog is increasing and because of the backlog we are not doing any intake in the area...so all abandoned children, abuse matters etc. are referred to the Department of Welfare...but this is going around in circles and the clients are being redirected to us...but we are refusing to attend to the matters...not because we don't want to ...simply because we cannot cope...it's a state of crisis...and the clients are moving to and fro without any services being rendered to them....it seems as though this is falling on deaf years...this is seriously impacting on children .... Families ....the community. At one time we only had 1 social worker in that area and this lady was really losing it...she didn't know what to do...she had to do intake, clients from the social workers who had resigned...her clients...she was totally stressed and could not cope or function. The Department is very much aware this...various meetings upon meetings were held, but nothing has come of it...no progress has been made."

"Burnout and stress is due to the high caseloads...and the need to deliver...statutory intervention...abiding by return dates...writing numerous reports...challenges in terms of dealing with different courts, children's homes, various organisations ...they become very stressed...the volume is enormous and overwhelming. In our society we had to take posts from one area and redistribute to another area due to the exceeding high number in that area with the result that the initial area social workers were also inundated...its just a case

of redistributing posts within loads that were exceedingly high...this did not ease the situation as all workers felt overburdened and stressed. Ideally with the increase of statutory loads, there should be an increase of posts from the department, but this was not forthcoming so the agency had to find its own means and measures of alleviating stresses and rendering services. But redistributing posts does not solve the problem but in fact adds to it. The agency is really really struggling to cope. Ideally more posts are needed.... parity of salaries will be a turning point for child welfare organisations."

"In reality, however, the posts are not enough. ...if you really and truly want to render a professional social work service ...not 1 but 2 more social workers are needed for that load. Social workers are carrying up to 200 cases." This further compounds stress and burnout among social workers and the staff turnover has a serious negative impact on service delivery as expressed by numerous respondents.

According to Ntusi (1995) and Hodge (2004) the professional identity of social work does not compare favourably with other professionals as social work revolves around the disadvantaged, the disabled and the destitute and they generally tend to be associated with poverty. In addition, the residual nature of social work services and the lack of adequate resources to provide effective programmes have lowered the status and worth of the profession. These factors contribute to the profession being perceived as ineffective, unimportant and inefficient. This has a dehumanising and demoralising effect on social workers. Social work was perceived as an extremely demanding job, both potentially dangerous and unappealing by the respondents in this study. More specifically the day-to-day tasks envisaged e.g. problem solving was perceived as difficult, unpleasant and frustrating. The majority of the respondents in this study called for better salaries and service conditions to curb the high turnover of social workers.

This indicates the seriousness of staff turnover, which negatively affects service delivery. With the increasing number of caseloads in view of the increase of orphans as a result of AIDS, this will lead to a deepening crisis in welfare organisations.

The following respondent also expresses these concerns. "When we first made entry into one of our areas, it was grossly under resourced and underserved. Initially we only had 2 posts and now we have established 21 posts in this area mainly because of the increase of orphans...but...we were not given more posts from the state...we had to take existing posts from other areas and redistribute and allocate to this area...because of the exceedingly high numbers from this particular area... this had created added stress and overload to certain areas...and groupwork and community work was neglected. The demand for services in this area was so great.....we really had no choice."

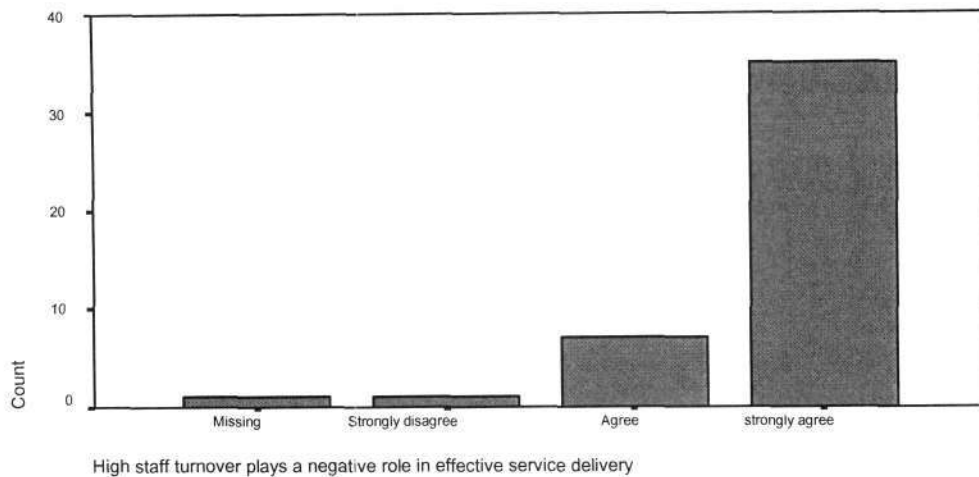
#### **Adequate Staff and training capacity**

According to Hall (2003), there exists a huge shortage of social workers in most countries. This is applicable to South Africa as indicated by the following respondents interviewed:

"Regarding shortage of social workers, a huge problem is the availability of social workers. The situation is so critical that social workers do not arrive for interviews, or if they accept a position, they sometimes do not arrive to take up the position. The average length of stay in the NGO sector is dropping to under 6 months per social worker. In some cases social workers accept a position and then do not turn up." Some organisations indicated that they resorted to employing auxiliary social workers to fill the posts of social workers.

Burnout and stress invariably leads to high staff turnover, which also has an impact on service delivery. Respondents' views regarding staff turnover is illustrated in the following graph.

TABLE 2: HIGH STAFF TURNOVER PLAYS A NEGATIVE ROLE IN EFFECTIVE SERVICE DELIVERY



The majority of respondents acknowledged that turnover is affecting service delivery. The staff turnover figures given by one of the organisations are as follows: "From 1.10.2001 to 30.09.2005 there were a total of 132 resignations from social work staff. "Other organisations reported the following:" In 2003 we had 16 resignations ... 2004 we had 18 resignations and in 2005 we had 17 resignations. Prior to that in 2002 we had a 100% staff turnover. From 2002-2003, loss of staff was impacting severely on efficiency, effectiveness, and accountability. The professional image of the organisation was severely damaged. Only the experience and expertise of the managers enabled us to continue to run services in a professional manner. The turnover increased with more social workers going to work for the State Department of Welfare. Social workers barely completed a full year with us. We had become a training body for the Department of Social Welfare and Population Development. Our professional capacity was seriously dented. In 2004 the situation was no different."

The responses from the interviews and questionnaires clearly indicate that trained staff is a shortage and impacts negatively on effective functioning in the arena of HIV/AIDS.

The following overall responses support the above findings. "Previously training programmes were scheduled for the entire year. These were co-coordinated and implemented by the social work managers. Since last year training programmes have been dropped because the statutory loads have become overwhelming and difficult to cope with. Firstly, it requires a lot of planning, organisation, time and effort from the managers...due to the managers themselves being affected by staff turnover and orientating new staff and increasing loads, this was not feasible and practical for them. In addition, the heavy statutory load whereby they also could not commit themselves to attending the training programmes also bogged down social workers. In addition, it was found that new social workers come to the organisation, attend these training programmes and then leave... So it is a waste of effort... We also experienced problems in employing trained, senior black managers, which was difficult to recruit. Senior black managers are scarce and are becoming a scarce commodity within the child welfare organisations. There is indeed a strong need... however, most of them are recruited by the Department of Welfare obviously for higher salaries benefits and positions. But those that have left the Department and have taken their packages come to work for us. We have a few senior black social workers but majority of the black social workers are newly qualified social workers."

Thirteen respondents (29.5%) indicated that the agencies do have trained staff to render services to children and families affected by HIV/AIDS, whilst 30 respondents (68.2%) indicated that the agencies do not have trained staff to render these services. Thus one can conclude that social work agencies generally do not have adequate trained staff to deal with HIV/AIDS.

With regard to adequate staff being a contributory factor towards coping with the challenge of HIV/AIDS, the responses were as following:

**TABLE 3: ADEQUATE STAFF TO RENDER SERVICES TO CHILDREN AND FAMILIES AFFECTED BY HIV/AIDS**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	36	81.8	83.7	83.7
	Yes	7	15.9	16.3	100.0
Missing	Total	43	97.7	100.0	
	System	1	2.3		
Total		44	100.0		

It was found that 36 respondents (81.8%) do not have adequate staff to render services to children and families affected by HIV/AIDS. Seven respondents also indicated "a separate social worker should be employed to deal with AIDS related issues"

Another respondent noted: "We are also trying to motivate for more statutory posts so if the social workers have smaller caseloads, they can devote some time to group work and community work."

"I am a social work manager but also exercise the role of the Director and Senior Social Worker. We don't have a Director, which is actually a very big problem for an organisation like ours... and with the result that the social work manager and senior social worker get saddled with a lot of things that the Director is suppose to do. We become a combination of managing social workers as well as fulfilling the functions of the Director...from funding...to proposals... to stats...social work interviews...all this becomes my responsibility. We do this at the expense of social work itself.... this has a serious impact on our clients. The impact of AIDS has further compounded the problem."

The findings regarding a separate HIV/AIDS unit indicated that 88.8% of the respondents do not have a separate section for HIV/AIDS and 86.4% indicated that they do not have an AIDS coordinator. One of the AIDS coordinators gave reasons for the importance of the unit, which is illustrated as follows:" I think it

came about from research conducted and the findings identified one of the areas with the highest rates of HIV infections so they motivated and negotiated for the AIDS unit to deal separately with AIDS especially since the numbers of orphans were increasing and they needed special services and attention. So to fulfill this need. We had to apply for it because we saw the need for the programmes. We were very caught up with the 'orphan' problem and having to go through the statutory cases, the numbers have been increasing at an alarming rate...The need for statutory services and intervention was also increasing and this leaves a gap in support services to the children affected by AIDS. The workers were not able to do any community work that needs to be done hand in hand with statutory work ...that is why we established a separate unit, which would be dedicated and committed, and we could focus on AIDS and meet the need as we felt that that the statutory processes and intervention does not meet the need alone...and we needed to look at the broader, holistic perspective to service delivery in the community ...being involved to provide support to orphans in helping the community to take on social responsibility ...because eventually it is their children and the community needs to make sure that they care for the children. And it is with all this in mind that it was set up. This is why we are looking at the different childcare forums. We are trying to allow the community to accept responsibility.... we are working as catalysts...working with the frontline workers i.e. leaders in the community...ensuring that those processes are facilitated. With the over-whelming number of statutory cases, it is not possible to provide an effective service. We are averaging of about 100 to 120 cases per worker ...the increase of statutory work...ties the worker totally to the statutory caseload, so in terms of group work and community work, this is not possible and also important aspects such as awareness and prevention re: AIDS is neglected ....so it is absolutely essential that we do have a sector that is totally committed to dealing with all aspects regarding AIDS.

Inadequate and untrained staff further compounds stress and burnout among social workers and the staff turnover has a serious negative impact on service



delivery as expressed by the following respondent. "It impacts on community development. In terms of services, we have ensured that the core service i.e. statutory still continues to function. Statutory is still a key factor but, backlog occurs e.g. orphan care, the applications, also birth registrations etc. delays surrounding this...also creates a backlog..."

An important finding from the interviews was that despite the high turnover amongst the organisations, there still existed a few key dedicated and committed staff members who continued to work within child welfare for a number of years. Four respondents from the interviews stated that they were employed by child welfare between 10 and 31 years. Some of the reasons attributed were dedication, commitment, love and passion for working with children and a feeling of fulfillment in assisting children. Of significance was that 4 of them stated that it was their choice to work for child welfare and some of the positive factors included flexibility, ability to practice a specialised field such as foster care or adoption and convenience regarding structure compared to state departments. One respondent stated the following regarding dedicated staff. "Fortunately, I have a very good management staff whereby almost all of them have been with the organisation for at least 10 years or longer. The rest of them have at least 15 to 20 years experience with other organisations. The management is able to hold things together...because of this stability...the strong foundation upon which the organisation is able to function in the face of adversity...their individual and combined experience is the strength and pillar of the organisation...especially in the light of the high staff turnover."

### **Low Salaries**

Eighteen respondents from the study stated increased salaries, as part of the recommendations in coping with the HIV/AIDS pandemic. An overwhelming majority of respondents i.e. 90.9% felt that parity of salaries between the Government and the NGO sector would have a positive impact on service delivery. An important point is that although child welfare organisations are

disadvantaged in terms of salaries compared to state social workers the overall salary structure is still lower than other professions.

Another important concern raised by the social workers was that they found that there are many social workers with over 5 years experience and some recognition needs to be given to the differences between these experienced staff and newly qualified social workers. This is indicative of the salary structure within child welfare organisations. As one's years of experience increases, the salary does not increase accordingly. In fact, the salary structure benefits and attracts inexperienced and newly qualified social workers rather than experienced social workers. In this respect, one of the respondents said: "...we have a more serious problem than other child welfare organisations...all social workers i.e. managers and social workers receive exactly the same salary...there is no distinction...this really attributes to the particularly high staff turnover for this organisation...a year later this has not changed and I can see social workers leaving this agency...and the problems are getting worse."

### **Image of the Profession**

The concerns expressed by some of the participants regarding the image of social work and its impact on the nature of its functioning is supported by the literature according to Schachter (1998:1) "There are few things more frustrating to social workers that the portrayal of the profession in being grossly distorted and negative. With social work being as difficult as it is, especially given the limited public support for programmes and less than satisfactory working conditions." One respondent stated that: "We are hoping that the process towards parity will continue and be accelerated at a faster rate. For the social work profession as a whole ...for the social worker to feel valued...to feel proud of the profession...to enhance the status of the profession..." Another respondent stated, "...There exists lack of commitment and dedication from the new social worker ...the social work ethic does not exist anymore. The whole profession is in a phase of transition...more in a state of crisis...I don't know if we

will ever come out of this...and the situation is getting worse...the state needs to seriously look at the profession of social work...increase the salaries to a marketable level...so more people will be attracted to the profession and also they will be able to render a professional service ...this needs to be seriously addressed...and it is really critical...this is a priority...it has to happen...for the sake of the country...and also to have more posts allocated ...and to slowly improve the conditions for social workers.”

Another respondent vocalises the importance of the loss of professional skills.” The loss of professional skills and looking at the difficulties of the last 20 years, we can honestly say that we are currently no better off than we were in the past, through not having sufficient subsidy cannot pay salaries equivalent to those of the State. We have had more than 100% staff turnover of professional staff in the past year. The managers have supplied the community and experience. No business or corporate body would survive such a loss of capacity and skills. The loss of professional experience and expertise is immeasurable.”

Many of the respondents felt that although social work has moved in the direction of professionalism compared to the past, its workers should receive salaries large enough to permit them to maintain a professional standard of living, comparable to other groups requiring similar education and training and sufficient to compensate for the cost of their preparation. Social work salaries are not sufficiently high to provide opportunities for travel, study or for professional growth. The salary situation is also a misfortune from the point of view of professional prestige. This view is also supported by Banhorst (1989). Some of the frustrations of the interviewees are related as follows:

“... because there is not much scope and I really want to leave the profession but finding something alternative to social work is really difficult...but definitely... practicing social work is really difficult...the working conditions...the low status...the salary...the mundane job. Lets say that you qualified as a social worker...from there you would remain a social worker unless there are openings

which is so difficult. Some agencies recognise you as a senior social worker...some don't. If you are lucky sometimes, you apply for a manager's position and you get it. But, this is also so difficult as most of the managers of child welfare settings stay with the agency so it's a challenge for social workers to get to those positions. Further to that, there is nothing much...having to do your masters and doctorate in social work does not take you far. If you are a manager, that's it...it's a dead end...the job is dreary and mundane ...its very hard...even within your own organisation. Sometimes you have to have 10 years of experience to become a manager ...because there is also nothing else for them... and working conditions are appalling... whichever child welfare setting one works in...its generic...the problems...offices may look neat...prim and proper...but this is very very superficial...social workers are very very frustrated...suffer from burnout and stress ...are not recognised...are not valued...as I mentioned on the surface things look okay, but, the actual day to day running and functioning of social work is...very challenging. There are lots of other things...unique problems to each welfare organisation, so for me getting out of social work will be the best...for my own sanity...but it's absolutely difficult, but I am trying. If I can get out and get something better, I am not going to sit back. I will look for greener pastures whether it is in social work or something else. I have also done a HR course so I am open to that field as well."

### **HIV/AIDS challenge for Social Workers**

HIV/AIDS is a critical challenge faced by social workers in child welfare organisations. The following table illustrates this.

**TABLE 4: AIDS HAS PRESENTED ENORMOUS CHALLENGES TO OUR AGENCY**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Disagree	1	2.3	2.3	2.3
	Agree	21	47.7	48.8	51.2
	Strongly agree	21	47.7	48.8	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

An overwhelming majority (95.4%) of the participants agreed that AIDS has presented enormous challenges to their organisations, which are already under sourced and over-stretched. The responses from the participants further validate this point by stating that the placements for the numbers of abandoned babies have increased as a result of HIV/AIDS." The impact of HIV/AIDS has skewed services so that most resources and services are geared to serving children infected or affected by HIV/AIDS. The emotional and economic impact of the disease on the children and their families necessitates the provisions of services to the sick and dying parents, the need to protect orphans from neglect, exploitation and stigmatisation by communities and extended families. Services had to be rendered to some rural communities that fall outside of traditional boundaries, as these communities were so desperate for services to their children as there were no other service providers in the area."

"According to one respondent, the figures for statutory services are extremely high as given for 2005. 649 Children's Court enquiries were undertaken and 768 children were placed in alternate care. As at 31 March 2005. 3840 children in foster and kinship care and 250 children at institutions were being supervised. The organisation is already offering support to approximately 6000 orphans. In the vast majority of the cases the overwhelming problem is poverty. Although grandparents may wish to care for the children they often only have a small pension and have no money for the additional food, clothes and school fees. The majority of orphans are living with extended families. Issues for these families include improving the ability of the family to cope, financial and psychosocial support and access to health care and education. Given the AIDS pandemic, this programme continues to grow and our Society's resources are becoming increasingly stretched. The number of children in statutory kinship care is 3346."

The results revealed that a total of 40 respondents (90.9 %) stated that due to statutory work less time is afforded to the care and support of children infected with/ affected by HIV/AIDS.

### Incentives or team building morale

It is important for an agency to provide incentives or team building morale to support the social workers in order to achieve a sense of personal accomplishment and from burnout and psychological strain to be reduced.

The overall responses of organisations providing incentives or team building is as follows:

TABLE 5: INCENTIVES TO BOOST MORALE ARE PROVIDED BY OUR AGENCY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	29	65.9	67.4	67.4
	Yes	14	31.8	32.6	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

The responses indicated that 65% of the agencies do not provide incentives or team building morale to support social workers. This is an important area that management needs to focus on, as recognition and value for social workers can reduce staff turnover to a certain extent. Respondents stated that social workers need to be taken care of by the management of the organisation and resources such as psychotherapy; trauma counselling and other staff incentives should be accessible...A quotation from one respondent aptly describes this aspect: "...I think we are really missing something so badly as a profession...look at the trauma the social workers face...its well and good setting up the fancy teams, etc. but focus also needs to be on attention and care of social workers. The emotional impact on social workers...this understanding is lacking....special funding has to be devoted to this aspect..."

### Inadequate Resources

According to the findings, lack of adequate resources can also contribute to frustrations and feelings of inadequacy in rendering of services to clients. This is supported by Hasenfield (cited in Gillespie, 1987:15). Respondents in this study recommended that greater resources be provided to facilitate service delivery.

One respondent stated, “ a recommendation would be to have more resources accessible to clients,” with another asserting, “All social workers need to have direct access to knowledge and appropriate resources applicable to children infected and affected by HIV/AIDS.” Another respondent stated “lack of adequate resources make it even more difficult for us to practice as social workers, sometimes we are banging our heads against the wall.”

The overall responses regarding lack of resources contributing towards the challenge of HIV/AIDS are as follows:

**TABLE 6: INADEQUATE RESOURCES HAVE CONTRIBUTED TOWARDS THE CHALLENGE OF COPING WITH AIDS**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	12	70.5	72.1	72.1
	Yes	31	27.3	27.9	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

Almost seventy one percent of the respondents indicated that lack of resources has been a contributing factor towards the challenge of HIV/AIDS and emphasised that this had a direct impact on service delivery. Many of the frustrations relating to lack of resources included transport, safety, office space and funding. In the words of one of the respondents: “another challenge we are faced with is that of lack of resources. We have only one vehicle for 7 of us and we have to be here, there and everywhere...the vehicle has to be shared and as a result the social workers often have to resort to using public transport. which has its own difficulties...such as delays etc... safety is also a challenge...in reaching the community. Sometimes there is a fear because of certain crime-infested areas...they often have to go alone...But I think overall lack of resources and funding is a very serious issue that hampers service delivery...if we have more funding...presently it is very limited which makes it quite difficult to do some of the things we need to.”

### Support from National Council for Child Welfare

The results indicated that a total of 25 agencies (19 rural areas and 6 urban) i.e. do not receive support from the National Council for Child Welfare.

### Funding and Government support

Funding and government support are critical and significant factors in contributing to an organisation's success in coping with the pandemic of AIDS.

The overall responses in terms of government funding is illustrated as follows:

TABLE 7: ADEQUATE FUNDING HAS CONTRIBUTED TOWARDS COPING WITH AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	34	77.3	79.1	79.1
	Yes	9	20.5	20.9	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

An overwhelming majority i.e. almost 74% indicated that funding was inadequate in coping with the challenge of HIV/AIDS. Several respondents recommended that Government must increase its funding to enable child welfare organisations to function effectively. "...It went on for 3 years till 2001 and then the unit had come to a halt as the funding was depleted. However, funding was reinitiated in May 2005. Normally, the funding is for a period of 3 years. So presently, the funding is available from 2005 – 2008. Thereafter, we will have to remotivate to have access to funds again and in order for the unit to continue being functional and operational."



The overall responses regarding government support is illustrated as follows

TABLE 8: GOVERNMENT SUPPORT HAS CONTRIBUTED TOWARDS COPING WITH HIV/AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	25	56.8	58.1	58.1
	Yes	18	40.9	41.9	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

The study assumes that government support is prevalent in some organisations whilst absent in others, as 56.8% of the respondents indicated that the government has not been supportive towards coping with AIDS, while 40.9% indicated that government has been supportive. However, of importance is that some of the respondents indicated that government support was only in the way of subsidies. Perhaps, other organisations cited subsidies as government support.

The frustrations regarding government support is aptly described by some of the participants as follows: "...to add to the frustrations...we also do not get support from the Department of Welfare. In view of the high caseloads they do not understand ...they often have this requirement...and that requirement. This report...and that report...this impacts heavily on the organisation ...we cannot cope...we tried to reach to the Department of Welfare. The lack of support and administrative delays from the Department of Welfare is very frustrating...the delays of orders...sometimes for years...affects the grants...grants getting stopped...and the Department refuses to acknowledge that they are sitting with a backlog." To further illustrate this position, some of the respondents indicated that there was no clear partnership between the state and the child welfare organisations and as a result, organisations are ill equipped to deal effectively with the AIDS pandemic. Sixteen rural and 7 urban areas stated that government was not a contributory role player. Thus we can assume that rural areas receive less government support than urban areas.

The majority of responses pointed out that there was a serious lack of funding and government support in assisting child welfare organisations with regard to their responses in dealing with AIDS. This has serious consequences for child welfare organisations with regard to their coping mechanisms and responding to the challenge of HIV/AIDS, as they are already under-resourced, overburdened and over-stretched.

A comparison between urban and rural areas indicate that 5 urban organisations and 4 rural organisations stated that adequate funding was a contributory factor while 13 urban and 19 rural organisations indicated that adequate funding was not a contributory factor. Thus we can conclude that although adequate funding is insufficient for both rural and urban areas funding is available to a slightly greater extent in urban areas. South Africa's adoption of the neoliberal macro-economic policy might be one factor that contributes to the lack of government support of funding the NGOs.

## **Conclusion**

HIV/AIDS has serious consequences for the country as a whole including child welfare organisations. It is frightening to imagine how child welfare organisations are functioning in relation to the growing pandemic within the context of lack of government funding and support and how they will continue to function in the future if government continues to treat this pandemic without an emergency and priority response. These findings indicate that burnout and stress, high staff turnover, inadequate training of staff and lack of appropriate supportive structures including government support and funding is a serious concern for child welfare agencies. Chapter Seven highlights the important findings in relation to child welfare's adoption of the principles of the developmental approach.

## **Chapter Seven**

### **ANALYSIS AND DISCUSSION: DEVELOPMENTAL APPROACH**

#### **Introduction**

The developmental paradigm as contained in the White Paper for Social Welfare (Department of Welfare: 1997) promotes a major shift in approach in the provision of welfare policies, services and programmes. This has particular implications for child welfare organisations as the challenges regarding HIV/AIDS are not included in the traditional function of child welfare organisations. In order to meet its existing demands and the pandemic of HIV/AIDS many child welfare organisations have strenuously advocated for the expansion of the boundaries of the child welfare system. Consequently, it is believed that the organisations are failing to meet new expectations but are also experiencing difficulty in carrying out its original goal of providing for children whose basic needs cannot be met by families or communities.

#### **Overview of findings**

##### **Developmental Approach**

The majority of the respondents (almost 70%) indicated that they are adopting the developmental approach. However this is happening at a slow pace and serious difficulties are experienced. The following responses from three participants from the interviews support this. "...our Society is guided by the developmental principles. This includes accessibility to clients, accountability, affirmative action, availability, community participation, democracy, sustainability, transparency and the principles of Ubuntu" "...to an extent, work is being done in

that direction...but we stagnate at times because of staff turnover and crisis intervention ...we are unable to adopt that methodology all the time...we do try our best...but at the same time it is difficult. In the past, in terms of social work services, it was more specialised ...we had specialised teams and the staff complement was much larger. We had separate sections for foster care, adoption, intake etc...over the years due to the depletion of resources...high turnover." According to another respondent, "We try to run programmes throughout the year. In the past we were very successful, but due to turnover we have experienced problems...but for the period of time...because turnover has been high, these projects did not receive much attention because casework took precedence...but what happened...we try to have 1 major project or programme annually and we have tried to do that even in the last year and a half. This year we have looked at projects...we are still in the planning stages. It has been difficult to sustain and due to turnover it had to come to a standstill. Our child protection programme was at a standstill at one point...we were unable to do anything...workers were resigning...leaving ...new workers were coming in...new workers were leaving...new workers were trained ...they were leaving...there was no continuity...so we could not do anything major"

"...the policy changes, I think the whole transformation since 1994, with the developmental approach...policy changes had to be implemented in terms of minimum standards...we provide tools for developmental assessment of children...training of social workers...even casework has to be developmental, although we are not able to do group work and community work to the extent that we are suppose to be doing, developmental approach is part of the policy...but to what extent it is implemented is depended on the social workers themselves. Community work is also part of the policy. Community development is a strong focus but the large numbers in casework has made it difficult to do that work and staff turnover has also affected this..."

### **Finding cost effective ways to utilise existing resources**

The results of child welfare organisations with regard to finding cost effective ways to utilise existing resources revealed that 40.9% agreed that finding cost effective ways of utilising existing resources has not been practical within child welfare organisations.

The findings are further elaborated as illustrated by the responses from the following interviews: "The Society has managed the redistribution of resources; the focus of services has shifted to include various responses to the impact of the AIDS pandemic. We need more personnel...more funding regarding human resources definitely...they have not created posts but expect us to deal with the increasing numbers." Another participant stated: "We need to stabilise and develop both our staff and the management structure, and forge a good working relationship that would ensure the smooth and efficient operation of the Society. We need to develop a fundraising programme that ensures regular monthly income to the society, which begins to address the problem of our monthly and overall deficit. We need to undertake a comprehensive evaluation of our service delivery and put in place a new system in keeping with our limited human resource capacity. These challenges, as well as others that are identified from time to time need to be addressed urgently to ensure the smooth operation of the organisation."

"The numbers of posts have not increased from the past 10, 20 years...maybe even longer, these posts have been like that forever. In 1991, we had the same number of posts. For a long time the state has stopped giving us additional number of posts. The posts have stayed the same but the number of cases has increased drastically. For more than 20 years, I have not seen any new posts. In light of the HIV/AIDS pandemic, this is of concern and in addition to render more services in terms of the developmental approach i.e. group work and community work. How is one able to render more services without increasing the posts? These are one of the conditions under which child welfare organisations have to

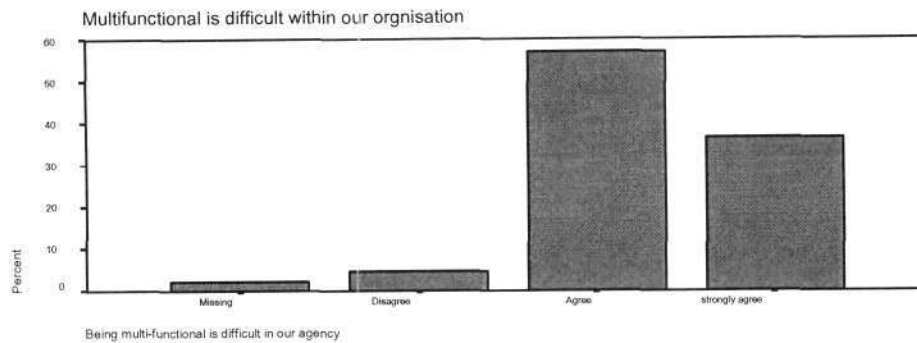
function. It is so blatant that funding is the same for more than 20 years. This shows the crisis level of social work...”

The above data reflects that while social workers are aware of the principles of developmental social welfare and the importance of implementing them, the high staff turnover, the demands of statutory work and the limited resources makes this very challenging. Indeed, in some instances development projects, including group and community work, that were implemented in the past came to a standstill on account of those factors. The demand that welfare agencies in the NGO sector do more for less is one of the features of neoliberal capitalism that emphasises curbing of state expenditure in health, education and welfare (Sewpaul and Holscher, 2004). It also appears that the concepts of self-reliance and empowerment have become two of the most misunderstood concepts in post-apartheid South Africa. They are often taken to mean that individuals, families and communities, and organisations rendering services have to pull themselves by their own bootstraps. What seems to be forgotten over time is the promise by the state for the creation of an enabling environment to facilitate the self-reliance and empowerment of people (Sewpaul, 2005).

### **Multi-functional**

The following responses indicated the degree to which child welfare organisations experience difficulty in being ‘multi-functional’.

TABLE 9: MULTIFUNCTIONALISM IS DIFFICULT WITHIN CHILD WELFARE ORGANISATIONS



An overwhelmingly majority of respondents (almost 90%), indicated that being multi-functional i.e. the ability to perform numerous tasks and functions is difficult to achieve within child welfare organisations.

Some of the responses from the interviews that illustrate this aspect are as follows:

"We were experiencing serious financial difficulties which at one point threatened to bog us down. However, scaling down our operational expenditure, recuperating excellent profits from the Fair and funding from Lotto have assisted in easing our financial position...but still lots of work needs to be done to sustain our efforts to generate additional income." Another respondent stated "The society had reviewed their services and they found that the absence of the homefinding team resulted in many children being institutionalised rather than be appropriately placed within a family setting." A third respondent that emulates this aspect is quoted as follows: "...we are working with the Department of Agriculture...they have promised to donate seedlings so that the food gardens can be started at home and ...also to share expertise and skills in this field. We are also negotiating with the Department of Trade and Industry to assist us with the Income generating projects but nothing has been finalised as yet."

One can conclude that although attempts towards change are being made, child welfare organisations are struggling in embracing the developmental approach.

### **Modification and Implementation of policy changes**

One of the respondents indicated their shift of philosophy and delivery as follows "Since the developmental model has been implemented in social work, the screening procedures are more flexible...not that we have dropped standards...but the important criteria still hold e.g. the applicant must undergo an HIV test...a medical has to be done...there has to be police clearance...references have to be provided...but I mean in terms of rigidity, they do not have to have a set income...or a massive house...or be at home to take care of the children...as long as proper arrangements are made to take care of the child. Even if a person lives in an informal settlement and has the means to take care of the child, he/she will be considered...because not all individuals in the informal settlements are poverty stricken...so in a way we are more inclusive than exclusive...also to increase the numbers of children in a family setting rather than the child being institutionalised."

Social workers in response to the new developmental model have to adopt the underlying principle of 'Ubuntu which reflects the ethos and spirit of social work. Contrary to the welfarist mode of practice the challenge for social workers is to identify and locate the place of clinical within the developmental paradigm. For the developmental approach to be fully integrated and incorporated into welfare, policies need to be adapted for effective service delivery for the developmental approach to materialise.

The following responses illustrate the extent to which child welfare organisations have shifted in the implementation of the developmental approach. The findings will be based on policies, therapeutic support services, programmes and special facilities within child welfare organisations.

### **Policy changes**

The responses of the agencies rendering services to HIV/AIDS infected and affected children are as follows:



**TABLE 10: AGENCY PROVIDES SERVICES FOR CHILDREN INFECTED WITH HIV/AIDS**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	6	13.6	14.0	14.0
	Yes	37	84.1	86.0	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

**TABLE 11: AGENCY PROVIDES SERVICES FOR CHILDREN AFFECTED BY HIV/AIDS**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	2	4.5	4.7	4.7
	Yes	41	93.2	95.3	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

The findings can be summarised as follows:

A total of 37 respondents (84.1%) render services to children infected with HIV/AIDS and a total of 41 respondents (93.2%) render services to children affected by HIV/AIDS. Only 13.6% and 4.5% of the respondents indicated that they do not render services to children infected and affected by HIV/AIDS respectively.

Some of the individual responses highlighting the policy changes included employing additional staff to address the backlogs and processing the documentation in relation to grant applications. However, these additional posts were dependent on availability of funding. Other responses included "these services are complemented by awareness programmes on prevention of HIV infection, prevention of neglect and abuse in terms of the actual working...the way we actually go about doing our screening...we have dropped our standards to some extent...if we look back we use to have 3 or 4 contacts with clients before processing any cases...now 1 contact is sufficient....and before all cases were discussed at a panel....right now because of what's in the best interest of

the child and the high numbers...we have to compromise some of the things...we are finalising lots of matters and we make quick decisions because at the end of the day we don't want to compromise the lives of the children."

Some of the respondents also indicated that they had to change their methods of working and functioning in order to cope with the increasing caseloads. Some of these changes are driven by policy shifts and pragmatic considerations as reflected by the social workers. However, there are obvious negative consequences to these: drop in standards, compromises and questions pertaining to whether the best interests of the child are indeed being protected.

### **Rendering of Services to HIV/AIDS Infected and Affected individuals**

The results for the approximate numbers of children infected and affected by HIV/AIDS, and the numbers of adults infected by AIDS were as follows: For the period 2004, the 31 respondents who provided the statistics indicated that: services rendered to infected adults totalled 2002, which ranged from 5 to 400; Services rendered to infected children totalled 1930 ranging from 8 to 250 per organisation; Services rendered to affected children totalled 16609 ranging from 10 to 6081 per organisation.

The above numbers indicate that child welfare organisations are rendering services to adults and children infected and affected by HIV/AIDS in large and increasing numbers. Chapter Two discusses how HIV/AIDS is placing enormous strains on an already over-burdened welfare sector.

### **Social workers Being Trained as part of Agency Policy**

The results for the responses of social workers being trained as part of agency policy indicated that according to 23 responses (52.3%) social workers are not trained to work in the area of HIV/AIDS as part of agency policy, and 20 respondents (45.5%) indicated that their organisations train social workers to work in the field of HIV/AIDS as part of agency policy. Therefore we can

conclude that in almost half of the organisations social workers are trained in the area of HIV/AIDS and the other half are not with regards to agency policy.

The results indicate that there exists a lack of trained staff in rural areas compared to urban areas as 9 urban organisations indicated that they have sufficient trained staff to deal with HIV/AIDS compared to only 4 rural organisations. 19 rural organisations and 8 urban organisations indicated that they do not have adequate staff to cope with the challenge of HIV/AIDS.

Therapeutic support services, programmes and special facilities play an important role in policy modification and implementation. The results for each category are outlined separately.

### **Therapeutic Support Services**

The responses to the memory box as a therapeutic support service by child welfare organisations are as follows:

**TABLE 12: MEMORY BOX AS A THERAPEUTIC SUPPORT SERVICE IS OFFERED TO CHILDREN AFFECTED BY AIDS**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	33	75.0	76.7	76.7
	Yes	10	22.7	23.3	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

Seventy five percent of the respondents stated that the memory box is not offered as a service. One respondent elaborated the difficulty in implementing this. "All social workers are encouraged to incorporate therapeutic support services to their clients. An intensive memory box training programme was afforded to all social workers 2 years ago whereby an 'expert' on memory box taught the workers certain skills and techniques regarding this important form of therapy...sad to say that most of those social workers have left the society...But the AIDS unit is implementing it to some extent."

The results for therapeutic support services-memory box with regard to urban and rural areas indicate that overwhelming majority i.e. 19 organisations from the rural area and 14 organisations from the urban area (including 4 servicing the rural areas) stated that memory box is not offered.

TABLE 13: THERAPEUTIC FAMILY SESSIONS ARE OFFERED

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	27	61.4	62.8	62.8
	Yes	16	36.4	37.2	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

The responses indicate that 16 organisations (36.4%) offered therapeutic family sessions to children affected by HIV/AIDS while 27 (61.4%) did not offer this as a service. The views on implementation and reasons for non-implementation are explained as follows by one participant: "Rendering therapeutic support services has been difficult ... we have lost that aspect because of the high caseloads. Each social worker is so overloaded and overwhelmed...in addition, abuse...marital etc. most are referred to other organisations. The social workers do not have the time to render that service and that would have been the ideal if we had a lower caseload, but its not happening. It's so sad, because with the kinship care all the orphans...bereavement, trauma...loss of parents...this is what people don't understand...you may have 200 or 300 cases on your load but nobody is going to tell me that it's a simple caseload...because those children...the very fact that they have been placed in foster care...there is trauma in itself...the children have started with a disadvantage and people don't understand this...but I think we are just caught up with just putting children in the statutory system...that's about all...because the numbers are just getting astronomical...its actually far taken over...hit us like a bomb...We have brand new social workers...they have 20 enquires...and they have to take on 20 new cases for the month...where does that leave the social worker? .... what is she suppose to do? the priority is to get the grants...what's happening with the

skills...the parenting roles.... I ask myself do we really need a 4-year training to render this type of service? If one has to analyse and assess the type of service rendered, and if you look at that...that will be shocking...social workers come in ... process the documents...we write beautiful notes... do counselling, render reunification...etc...but this is just on paper...no diagnoses is done...no proper evaluations are done... even with the 16(2): reports...no one is analysing them ...assessing them...that this child is benefiting or not benefiting.... I then ask myself do we really need social workers to do this... compromised so many standards in everything and we have no choice really...we have to really take shortcuts...otherwise we cannot cope and we are not really coping...and its going to get worse...because the numbers are going to increase..."

The results indicate that 12 urban agencies (including 1 servicing rural and urban) and only 4 agencies from the rural areas offer therapeutic family sessions. We can conclude that more than double urban child welfare organisations offer therapeutic family sessions compared to rural ones thus there is a clear rural urban difference.

**TABLE 14: BEREAVEMENT AND GRIEF COUNSELLING ARE OFFERED**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	24	54.5	55.8	55.8
	Yes	19	43.2	44.2	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

Forty three percent of the organisations as reflected by the study are rendering bereavement and grief counselling to children affected by HIV/AIDS, while 24 organisations (54.5%) are not able to render this service.

These findings are further supported by the following views: "Bereavement counselling was provided previously whereby one worker was employed as a bereavement counsellor for the entire agency and all clients that required this

service was referred to her. However due to lack of funding, this post does not exist anymore...due to the increasing numbers of statutory cases, this post was given to statutory services. But, we are still trying to motivate for funding so that posts can be achieved. Statutory intervention often takes priority because of the large numbers therefore a large portion of our programmes had to be curtailed. Our society continues to receive an increasing number of referrals of children who have been abused or neglected and children who are affected or infected by HIV/AIDS. In addition, during 2004, 74 children who were abandoned were brought to the Society's attention."

It was found that of the 3 support services, bereavement and counselling is practiced in almost 44% of the organisations while the memory box is the least practiced. This indicates that child welfare organisations have incorporated therapeutic support services as part of the agency policy, however it is obvious that some of them are experiencing difficulties in this regard.

The results for differences between rural and urban areas indicate that 16 respondents from the rural areas and only 3 from the urban areas (including 2 servicing rural areas) offered bereavement and grief counselling. Thus there is a distinct rural and urban difference in that 4 times as many child welfare organisations in rural areas use bereavement and grief counselling as a therapeutic service than those from urban areas. This appears to be an unusual practice. Possible reasons for this could be:

- 1) There exists a greater community and family awareness regarding death and dying in rural areas compared to urban areas, thus there is a demand and need for this service in rural areas rather than urban areas.
- 2) As a service, existing staff normally renders this and urban areas could be utilising their funding on visible programmes or projects.
- 3) The higher statutory loads in urban areas do not allow the social workers to use bereavement and grief counselling as part of social work intervention.

### Specific Programmes and Projects

The overall responses relating to programmes being in place for HIV/AIDS affected children can be illustrated as follows:

TABLE 15: SPECIFIC PROGRAMMES ARE IN PLACE FOR CHILDREN AFFECTED BY HIV /AIDS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	23	52.3	53.5	53.5
	Yes	20	45.5	46.5	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

Twenty organisations (45.5%) indicated that they have specific programmes in place to cater for HIV/AIDS affected children and 23 organisations (52.3%) indicated that they do not have special programmes in place. Thus we can conclude that child welfare organisations i.e. almost 50% have specific programmes in place to cater for HIV/AIDS affected children.

These responses indicate that child welfare organisations are making concerted efforts to facilitate programmes in terms of policy. The programmes highlighted by the respondents from the study can be summarised as follows. Nine respondents indicated that recruitment and training of crisis parents was an important aspect of their respective organisations as the crisis parents provided a nurturing environment for a short period for babies and young children in need of care. HIV/AIDS programmes which focused on discrimination, therapeutic services to individuals infected and affected by HIV/AIDS, preventative services that focused on proactive programmes in secondary schools, informative drama, talks and presentation at clinics, religious organisations and businesses were cited by fifteen respondents. Twelve participants indicated that Life skills programmes for learners in primary schools were an important focus of community work. The most common programmes included were on child abuse, children's rights and responsibilities, substance abuse and HIV/AIDS. Youth programmes in networking with youth from various rural and informal areas of communities were also important aspects for agencies as reflected 18

respondents. Some of the issues discussed were unemployment, STIs, drugs and substance abuse. Holiday programmes, which had a recreational and educational objective for children during school vacations, also constituted an important service for children as stated by 8 respondents. Foster care and Foster care programmes which focuses on issues such as the role of the social worker, roles and responsibilities of foster parents, requirements of the Child Care Act, guidance and relevant parenting skills, physical, emotional and social needs and development of the foster-child were reflected by majority of the participants as part of the agency programmes as indicated by 22 respondents. From the analysis it is clear that importance is placed on foster care programmes and HIV/AIDS as reflected by the majority of the respondents thus child welfare organisations are making concerted efforts within communities especially in view of the families and children affected and infected by HIV/AIDS.

However, obstacles and difficulties are imminent as aptly described by one of the respondents is as follows: "...we do have this programme...but it has come to a standstill because that funding has come to an end and it was headed by one of the managers...so when she left...the programme went to one of the junior managers...and she left...now its with a development manager...no more social work staff are involved. They have mobilised the community, made referrals...etc. it was functioning well...the basic structures have been set up in the communities and they are a big source of our referral. It's an excellent system but it has lost its impetus ...because turnover...the projects and programmes have been impacted.... overall some of the programmes have been going on but we have not been able to give it the attention it deserves."

### **Special Facilities**

#### Community Homes

Thirty-six of the respondents (81.8%) indicated that they do not have special facilities such as community homes. One agency described the success and



important role of the community home as follows: "Community homes also play a role. We have nine community homes in total and the first community home was piloted by our society. . The success of the Home depended heavily on active community involvement and participation in the planning, development, staffing and monitoring of each individual community home, facilitated by the Society's professional social workers. The main philosophy behind it was that orphans and vulnerable children requiring care should preferably be raised in family settings ... Area social workers are still directly involved in the statutory supervision of the children, although the community shares this role. As the children are seen as a group, this supervision is more time-effective than individual foster care supervision. The community family home, by caring for 6 children, potentially also provides more placements and therefore supplements the currently limited supply of foster parents."

### Foster Care

**TABLE 16: OUR AGENCY HAS SPECIAL FACILITES SUCH AS FOSTER CARE**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	3	6.8	7.0	7.0
	Yes	40	90.9	93.0	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

The results indicated that 40 respondents (90.9%) have foster care as a special facility. Some of the views on foster care as expressed by the participants are as follows:" Foster care has become a valuable resource to orphans and vulnerable children. There are, however, delays of up to 2 years in processing the grants...and fraud is rife in the system. The Department of Home Affairs has a backlog for the issuing of birth and ID documents. The need for services has doubled and our society is trying to identify OVC's as early as possible in order to reduce the impact of HIV/AIDS and poverty on children and prevent major disruptions in their lives. It is extremely important to meet the psychosocial needs of these children as experience of other countries which had battled with

HIV/AIDS longer than South Africa rated that those had failed to meet the psycho-social needs of the children were now dealing with the second generation of orphans as a result. It is thus so essential to involve community leaders and organisations in each community in order to act as resources for early identification of vulnerable children to reduce the possibility of neglect, abuse and exploitation of these children. Their grandparents are caring for more than 80% of the foster care children. We are seeing an increasing number of children who are in foster care being bereaved a second time as grandmothers and other members of the extended family are dying.”

Welfare organisations must find new solutions for the care of children, which make the best use of severely limited resources. The development of special foster care schemes is an option, which has not yet been given very much attention in South Africa. Such schemes require an initial injection of funds and some redirecting of resources to this area of work, but these costs are still only a fraction of residential care. If this option is not explored, South Africa could face a similar situation to that of Zambia which has been forced to re-open orphanages to care for the growing numbers children orphaned by AIDS (Glober, 1997).

### Adoption

Adoption as a model of care for children who cannot be cared for by their families of origin has unique advantages. However, the current South African adoption system is sometimes regarded as inadequate for children expected to require parental care as a consequence of the AIDS epidemic as discussed in Chapter Three.

The overall results with regard to child welfare organisations being successful in recruiting large numbers of black families as adoptive parents are as follows:

TABLE 17: WE HAVE BEEN UNSUCCESSFUL IN RECRUITING BLACK FAMILIES FOR ADOPTION

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	37	84.1	86.0	86.0
	No	6	13.6	14.0	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

The results indicate that 37 respondents (84.1%) stated that they have not been successful in recruiting black families for adoption while only 6 respondents (13.6%) indicated that they have been successful in recruiting black families for adoption.

The results of organisations being unsuccessful in recruiting large numbers of black families as adoptive parents for children infected and affected by HIV/AIDS are as follows. Seventy two percent as reflected by the results indicated that they have not been successful in recruiting large numbers of black families for children affected by AIDS and 36 respondents (81.8%) indicated that they have not been successful in recruiting large numbers of black families for children infected by AIDS. The data here are unusual as one would have expected larger numbers of respondents to indicate that they have difficulty in recruiting families to adopt HIV affected or infected children than getting families to adopt in general.

The qualitative response to support the above findings as indicated by one respondent is as follows: "It is difficult to recruit because culturally it is looked down upon and one is considered 'barren' or 'infertile'...they feel embarrassed to come forward...sometimes people come forward and pass the children off as their own. As much as we don't like placing children in that fashion, one needs to take reality into account. Sometimes the woman would say that her husband's illegitimate child is coming to live with them. So they would come to us to do a

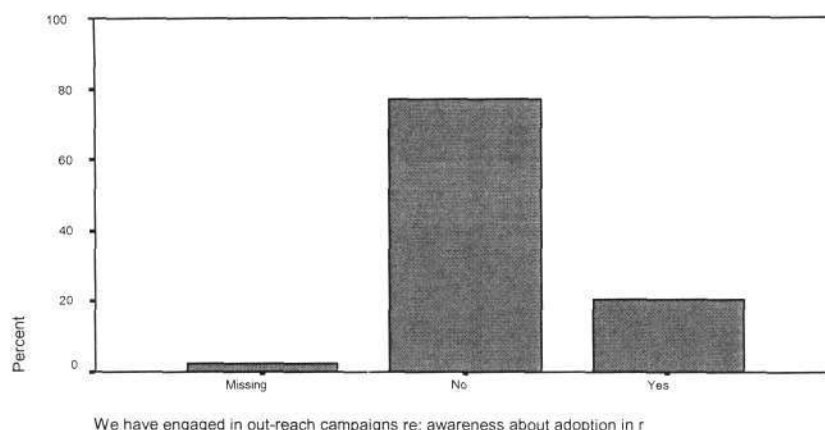
proper legal adoption and not announce it to the community. We have also had a few enquiries where black females made enquiries whereby they would pretend that they were pregnant even to their husbands...sometimes they could miscarry and carry on pretending they were pregnant. These individuals call us to adopt, as they are too afraid to let their spouses or family know that they are infertile or have lost their child. Some confess to their spouses but not to their families. Some have families in the rural areas, so they inform their extended families that they are going to have the baby in the rural areas and come back to the cities with the adopted child. However, we encourage black applicants to perform the same rituals for the adopted child as they would for their own child”.

The above findings are in accordance to the literature presented in Chapter Three regarding negative attitudes towards adoption that are still prevalent. However, the positive responses of 25% indicate that attitudes are changing to a certain extent. Some of the reasons for the success could be attributed to the fact that some organisations are changing their methods of recruitment and black families are being more open regarding adoption.

In addition, Collins (1999) proposed that ‘ubuntu’ being an integral part of African culture, may explain why black families are more open to adoption. ‘Ubuntu ensures that those in need are helped by others, with the understanding that when the helpers fall on hard times, they in turn would be assisted by those in the community who were able to provide help.

The results indicate that almost 80% of child welfare organisations have not engaged in out-reach campaigns to raise awareness about adoption in rural areas. This has an impact on recruitment and availability of adoptive parents as indicated in the earlier findings.

TABLE 18: ENGAGEMENT OF OUT-REACH PROGRAMMES RE: ADOPTION



Respondents' experiences regarding difficulty in recruitment included poverty, ignorance, the taboo factor, the lack of staff and funding to engage in awareness campaigns in rural areas and the high caseloads and staff turnover. One respondent felt strongly that there has to be a national campaign facilitated by the state for adoption to be successful.

A total of 36 respondents (81.8%) indicated that if adoption allowances were introduced this will have a positive impact on the recruitment of adoptive parents for HIV/AIDS affected children. This will definitely increase the numbers of adoptive parents in view of escalating numbers of orphans. However, some participants felt that this has to be carefully monitored and supervised and the motivation for adoption should be thoroughly explored.

### Other Facilities

The findings from the study reflected that 81.8% of the respondents indicated that they do not have other facilities related to children infected and affected by HIV/AIDS.

Some of the facilities as indicated include Children's homes. One organisation stated that they had 4 children's homes in total and each one caters for different needs and have specialised sections within them that provide for a specific need.

One of the children's homes has a special unit that caters specifically for street children. Special training is provided to them so that they can learn some skills. The shelter provides a vital need as most of them are orphans and the numbers of children requiring the protection of a shelter has been on the increase. Various courses such as electrical and catering and skills such as mat making and basket making is taught. An Adolescent Development programme, a therapeutic programme, is also a main component of the programme. Another children's home has a special HIV/AIDS unit for young children where most staff in-service training focuses on HIV/AIDS and, more especially, the ART rollout.

It is thus evident that some of the organisations are making special provisions for children in need of care especially in incorporating HIV/AIDS as an important component within the facilities of the childrens home.

### **Provisions made for pre and post test counselling**

**TABLE 19: PROVISIONS ARE MADE FOR YOUTH FOR PRE AND POST TEST COUNSELLING**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	39	88.6	90.7	90.7
	Yes	4	9.1	9.3	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

The responses are as follows: 88.6% of the respondents indicated that they have not made provisions for pre and post test counselling. However, 84.1% of the organisations were referring clients for the service.

### **Awareness and preventative programmes**

The results of responses of child welfare organisations offering awareness and preventative programmes in terms of agency policy were as follows:

TABLE 20: AWARENESS AND PREVENTATIVE PROGRAMMES ARE OFFERED TO YOUTH WITHIN OUR AGENCY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	No	12	27.3	27.9	27.9
	Yes	31	70.5	72.1	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

Thirty-one organisations (70.5%) indicated that they offer awareness and preventative programmes. Thus child welfare organisations are successful at offering awareness and preventative programmes with regard to HIV/AIDS to the youth.

### Specific Community Based Projects

Community projects should be designed to meet the basic needs of the community and carried out in response to the expressed needs of the people and not on the whim of an elite group. The overall responses of the study of child welfare organisations being able to focus and actively engage in community-based projects are as follows. The projects described by the organisations are as follows: Seventeen organisations stated that they have a Child Protection programme and this constituted an important project of their organisation. Thus this appears to be a core service whereby child protection programmes are worked in conjunction with schools, local libraries, etc. Sufficient time is dedicated for this project, which varies from 1 week to 1 month. Children and teachers from various schools are also invited to participate in the project via assembly talks and poster competitions, dances, poems, songs and short skits using child protection as a theme.

One organisation indicated that they are investigating the feasibility of establishing Satellite Homes. Like the Community Family Home construct, Satellite Homes provide pseudo-family care to 6 children in a family-type dwelling

developed in selected communities. The houses would be owned by the Society. The homes would be an extension of a particular Children's Home. It is envisaged that as Satellite Homes are developed, Children's Homes would become specialised facilities catering for children with special needs, serious behaviour problems or others requiring palliative care. Satellite Homes have the potential to afford children a family-type care with more individual attention.

The Eye of the Child Project initiated by one organisation has been successful as it has a trained volunteer base that takes on important roles and responsibilities regarding all child care matters. They provide a strong support structure for social workers especially in light of the high turnover of staff and the high caseloads.

Crèches also constituted as important community projects as cited by 25 organisations. It appears as though they were initiated to meet the needs of the working class community and the lower sectors of the community.

Eight organisations from the study stated that sewing projects serve as a necessary service to empower women, as unemployed women are trained in sewing, basic literacy, numeracy and budgeting and empowerment skills.

One respondent stated that they have a shelter for abused women and children. This is mainly for providing safety and a place to escape for women who fear for their lives. Here women are also empowered to exert their human rights and dignity. Community Fairs as a vital fundraising project was quoted by 3 organisations. This also created greater awareness for the organisation and served as a platform for marketing the organisation.

Community Garden projects, which is an income-generating project, is aimed at economic and social progress. This was featured by 17 child welfare organisations. The main goal was to encourage participation and discouraging dependence.



Toy libraries and homework centers were quoted from 2 organisations interviewed. These projects are designed to develop skills and they learn whilst playing and allow children access to an environment to study and completion of homework. Twenty respondents indicated that beadwork programmes were initiated to engage individuals in sustainable development. The objective of the project is to encourage positive living for people with HIV/AIDS by empowering them with income generating skills. Participants are monitored and provided with ongoing assistance if required. Marketing workshops were held to equip participants with marketing skills. One of the organisations stated that premises were obtained to market their items whereby beadwork items are sold to visiting tourists thus enabling members to generate an income and sustain the project.

Support Groups for HIV/AIDS affected and infected persons were part of the projects as identified by 18 respondents. It was reported that meetings are held on a regular basis and were attended by members. The objective was to provide moral support, therapeutic services and to provide relevant information on various issues affecting these individuals. Through this interaction with the HIV positive persons, valuable information is exchanged and social workers are better able to evaluate their needs and render assistance.

Only one organisation reported that they have a home for Senior citizens. This facility cared for and served destitute senior citizens. The Society extended its professional services with a social worker being twinned to the facility and there were also administrative employees who took care of maintenance, finance and other provisions.

Respondents unanimously agreed that community work was important in terms of prevention, and in sustaining and empowering communities. However, they were struggling in this regard. Some of the difficulties expressed were problems experienced were lack of person-power and commitment, lack of funding, high staff turnover and high caseloads.

The following extracts capture the difficulties and frustrations as vocalised by some of the respondents. "There has not been much change...but our services have been developmental to a certain extent...we are pushing out numbers...there is great pressure on us to do community work...the board of management does this...they measure the work we do ....not in terms of casework but community work...there is constant pressure on us. With us we have to undertake community work.... we don't have a choice...our professional function is different...our board of management have direct intervention on social work practice...we had to suspend some programmes...but most of them had to continue. Often we have to ensure that orders are not lapsing...etc...this becomes our priority...we've had to do that at the expense of other work." Another respondent stated: "The Child Protection team was unable to meet its objectives completely due to the crisis at the Society i.e. the high staff turnover."

From the results it can be concluded that that almost 50% of child welfare organisations have been able to focus and actively engage in community based projects, which indicate that child welfare organisations are making efforts to incorporate community involvement despite various difficulties, obstacles and challenges.

The results regarding rural urban differences indicated that 11 urban and 10 rural organisations are able to engage in community-based projects. The results also indicate that 13 rural organisations and 9 urban agencies (including 4 servicing rural areas) have not been able to engage in community-based projects. Thus there exists no distinction between rural and urban child welfare organisations in engaging in community-based projects.

### **Promoting community care rather than institutional care**

Promoting community care rather than institutional care was instituted by 50% of the organisations as indicated in the study. Thus half of the child welfare organisations in this study were adapting to and promoting change in terms of developmental welfare.

### **Volunteers**

Many organisations involve volunteers to maximise existing resources to render certain services. The positive responses regarding volunteers were as follows:

"Our agency has been successful in recruiting volunteers. We do have a strong volunteer base. We do get volunteers...for major projects and programmes our board of management and their spouses do get involved and come on board and help us quite a bit. We did have somebody in charge of volunteers...just to oversee the volunteers...and from time to time we do get people knocking on our doors... ..wanting to volunteer their services. At our shelter the Sahara, we have a regular group of volunteers...assisting us because at times we cannot cope...we get the volunteers to come in on a shift basis and it works like magic. The community members are quite open to volunteering their services. Sometimes we would place an article in the newspapers...the local newspaper and we would get a good response...an excellent response to it. At one time last year we placed an ad in the Rising Sun and the Phoenix Tabloid...we got a lot of volunteers...we were going to have a meeting after the advert...just after the advert hit the papers, we were flooded with so many calls, but we had to put the volunteer programme on hold...because at that point the turnover was high...extremely high and we couldn't have the volunteer meetings...so that whole programme had to come to a halt. But, we have other volunteers so they help with programmes, etc. For our Fair for example we get lots of volunteers that work annually at the Fair and its quite successful actually. We basically get volunteers through word of mouth...newspapers...we do not have to go out there on a strong recruitment drive like other welfare organisations...there is no need for that. Because we place an advert in the community newspaper as opposed to a national newspaper...that's what makes the difference I think. The fact that it is

in the heart of the community, the response is quite great...that is my observation. We get people coming in readily and wanting to help...and this may not be true of all child welfare organisations."

The results of the responses of agencies training volunteers to deal with HIV/AIDS are as follows: Almost 41% of the organisations indicated that volunteers are trained to deal with HIV/AIDS.

A high proportion of organisations indicated that volunteers are not involved on a regular and ongoing basis to provide services in the area of HIV/AIDS, and the difficulties experienced were as follows: "...we have lots of volunteers wanting to volunteer their services, but we don't have the time or space...we don't have a proper volunteer programme...we also get caught up with this confidentiality issue ...we need a full time volunteer co-coordinator. Previously we had 1 worker who only ran a volunteer programme and co-ordinate volunteers...we still have a group that raises funds for us and they go around selling...but in the office...the social workers are so overwhelmed...they cannot see to volunteers...its like student social workers...in the past we would attach them to the social workers...but now we find that social workers do not have the time to train, teach, etc." Another respondent's frustrations regarding volunteers was captured as follows: "We do have a group of volunteers but this is quite a problem in terms of commitment. Commitment is quite an issue for volunteers and they are not always available. The main reasons are financial difficulties due to unemployment...they are trying desperately to look for jobs, which are scarce...the minute they realise that they are not going to get paid, they lose interest. Sometimes it is not difficult to recruit them, but keeping them...sustaining them is difficult. At the moment we have volunteers per section but some sections don't even have any volunteers even though you let them know that there is no remuneration, they sometimes have an expectation."

Training and involvement of volunteers are an important factor in child welfare organisations, however although some success can be attributed to training and involvement, this aspect is often neglected.

The results reflecting the differences in rural and urban areas indicate that 9 urban organisations and 14 rural organisations found that volunteers did not contribute towards coping with HIV/AIDS. Thus rural organisations experience problems in this regard compared to urban organisations.

In practice, community care is often the responsibility of the female and not the community as stated in the literature review chapters. The findings regarding focus towards men as primary caregivers indicated that 68.2% of the respondents felt that the focus needs to change to men as primary caregivers and in addition, the findings indicate that 50% of organisations are pursuing this option.

### Poverty

Poverty is an important phenomenon that child welfare organisations have to deal with on a day-to-day basis. The impact of poverty in South Africa has a direct impact on the welfare sector. This is reflected in the findings.

TABLE 21: POOR ECONOMIC CONDITIONS HAS A DIRECT IMPACT ON OUR AGENCY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Agree	15	34.1	34.9	34.9
	Strongly agree	28	63.6	65.1	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

Almost all of the respondents (97.7%) unanimously agreed that the poor economic conditions in South Africa have a direct impact on the welfare sector.

Some of the responses that highlight the impact of poverty on child welfare organisations is reflected as follows: "In terms of commitment from clients, it is quite difficult, because the unemployment rate is so high...they are looking for jobs...they have financial difficulties...they often apologise and send other family members or representatives to attend on their behalf...but for the year they do attend a few times...so it is not a lack of commitment...but the circumstances under which they find themselves...their poor living conditions. We also have requests for initiating Income Generating projects. We haven't started this yet but there is a need for this."

Poverty is clearly linked to social security. The overall results of childcare support grants reducing some of the burdens on child welfare organisations are as follows.

TABLE 22: ACCESS TO CHILDCARE SUPPORT GRANTS HAS REDUCED SOME OF THE BURDENS ON C W ORGANS

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly disagree	6	13.6	14.0	14.0
	Disagree	17	38.6	39.5	53.5
	Agree	15	34.1	34.9	88.4
	Strongly agree	5	11.4	11.6	100.0
	Total	43	97.7	100.0	
Missing	System	1	2.3		
Total		44	100.0		

Child support grants reducing some of the burdens on child welfare organisations was supported by almost 50% of the respondents. However, we can conclude that as almost 50% agreeing that it has not assisted child welfare organisations in easing their burden in addition to shortage of staff, high caseloads and lack of resources and government funding.

Some of the respondents indicated that a well-targeted and well-managed social security can play an important role in meeting basic needs and alleviating poverty as supported by the Department of Finance (1998:1.3).

The overall responses regarding grants reflected that child support grants need to be increased to meet special needs of children and grants should be available to parents who live in poverty. Government welfare offices are at present ineffective, understaffed and foster grants are not processed speedily enough. One respondent firmly believed that advocacy on the part of child welfare organisations for institution of an across the board basic income grant would also reduce the bureaucracy and fraud involved in the existing grant system.

One respondent's view expressing caution regarding grants was as follows:

"We are making the biggest mistake...we are creating a society that is going to be totally dependant on the foster care grant...the foster care grant is not going to be affordable by the state on an ongoing basis...as this cannot be sustained...10 years down the line will the country really be able to afford this...nowhere in any of the other countries in Africa do they have a foster care system like ours...Uganda, Zimbabwe...they have had a huge HIV crisis, but they have not placed the children in foster care...the state is making concerted efforts to do programmes or projects. going into the rural areas...providing food relief...poverty alleviation programmes. The philosophy behind the Child Support Grant initially was extremely good i.e. for 5 years it gives the family enough time to get involved in a programme that has been set up...but all is lost...all the departments are suppose to be working together i.e. health, welfare, education, agriculture, public works, trade and industry etc.... nothing exists like that...each one works in isolation. all are doing little things all over...duplication of services in certain areas...under resourced in other areas...there is no co-ordination of services."

## **Conclusion of Chapters Six and Seven**

Chapters Six and Seven have served to detail the empirical findings of this study. The interpretation of findings relied on utilising the triangulated research paradigm, which incorporated both the quantitative and qualitative methods, as this was the most appropriate approach for the study's focus, objectives and research questions. By combining these 2 methods a general overall audit or snapshot was possible in addition to obtaining rich, in-depth information. By combining these 2 methods, it enriched the study and ensured that a maximum number of dimensions of the phenomena under study were tapped. This helped the reliability and validity of the findings.

It is hoped that by combining quantitative and qualitative research, the findings would provide readers with "a more substantiate picture of reality; a richer more complete array of ... concepts and a means of verifying many of these elements" (Berger, 2001:4).

The analysis of data was based on eco-systems theory. The methods used to analyse the findings were consistent with the theoretical framework that guided the study.

The findings of this study suggest that child welfare organisations in Kwazulu-Natal are struggling in responding positively to the pandemic of HIV/AIDS. Although various challenges and obstacles have played a key role in affecting service delivery, dedication and commitment of certain social work professionals within child welfare organisations have counteracted some of the negative factors and contributed towards addressing these gigantic phenomena in a positive and meaningful way.

The findings and principal recommendations are consolidated, summarised and presented in Chapter Eight.



# PART FIVE

## **PART FIVE**

### **Chapter Eight**

#### **RECOMMENDATIONS AND CONCLUSIONS**

##### **Introduction**

This chapter reintroduces the study's central issues that stimulated the research process. This includes the aim, research design, theoretical framework, and contributions of the study and research questions. A broad overview of the main findings are presented and linked to the study's theoretical framework. Finally, the principal recommendations from the researcher as well as those of the participants are discussed.

##### **Rationale and Context of Study**

The AIDS epidemic has placed various challenges on child welfare organisations, which are already overburdened and which are, unable to cope with the demands and pressures of high caseloads and staff turnover. In addition, due to lack of adequate resources and lack of government funding and support, child welfare organisations are struggling in terms of service delivery in general and specifically with regard to HIV/ AIDS. Hence, there is a need to address these specific challenges for effective service delivery and for specialised services within child welfare organisations to cater specifically for HIV/AIDS.

KwaZulu-Natal is the focus of the study. South Africa has one of the highest HIV/AIDS infection rates in the world and KwaZulu-Natal ranks fourth in the

country. Child welfare organisations are already burdened with the consequences of apartheid, which has resulted in a divided and somewhat unequal society in terms of mass poverty. HIV/AIDS adds a further problem on an already divided and 'abnormal' society. Thus the broad aim of this research is to investigate the various responses of child welfare organisations in the KwaZulu-Natal region to the challenge of HIV/AIDS.

### **Theoretical Framework**

As outlined in Chapter One, the study was guided by the ecological systems theory, which was viewed as an appropriate framework within which to contextualise this study. The essential aspect of this theory is the independent reciprocal relationship that exists between the given elements. In this sense, population change is related to cause and effect to environmental, social, organisational, technical and cultural factors. The ecological systems theory directs professional attention to the person-in-environment i.e. human problems develop as an outcome of transactions between environment and people.

Peile (1994) stated that the ecological systems theory has only gained strength over the last few decades. Its recent strengthening can be attributed to a vast array of ecological disasters, which potentially threaten the very possibility of human life such as HIV/AIDS.

HIV/AIDS may be likened to a stone dropped in a puddle of water. The ripples from AIDS move to the very edge of society, affecting first, just one person i.e. the individual himself, then the family, the community, the country and the entire nation. National and transnational factors such as globalisation affect countries, which affects policies that influence communities, families, individuals and child welfare organisations.

## **Research Design**

The researcher used the triangulated research paradigm, which was consistent with the theoretical framework of the ecological systems theory, which guided the study. Self-administered mailed questionnaires containing closed and open ended questions, combined with personal semi-structured interviews were utilised for the study as it was considered to be the most suited to the study's aim, objectives and research questions and was within the appropriate theoretical framework which underpinned the study. Careful attention and emphasis on design, data collection and analysis generated results regarding the responses of child welfare organisations to the challenges of HIV/AIDS.

## **An overview of the findings**

The main findings were consolidated in relation to each research question:

- 1) What are the responses of child welfare organisations in the KwaZulu-Natal region to the challenge of HIV/AIDS?
- 2) What policies have been modified or implemented to address the psychosocial and economic consequences of HIV/AIDS?
- 3) What is the staff and training capacity to cope with HIV/AIDS in KZN?
- 4) What programmes are available to children and their families affected by HIV/AIDS?
- 5) What facilities are provided for Pre and Post Test Counselling?
- 6) What facilities are available for orphans?
- 7) What awareness or prevention programmes have been implemented?
- 8) What are some of the obstacles encountered by the organisations in KZN with regard to HIV/AIDS?

The data collected in Part Four, Chapters Six and Seven are discussed to investigate these questions. This section presents a summary of the major findings.

**The overall responses of child welfare organisations in the KwaZulu-Natal region to the challenge of HIV/AIDS**

There were conclusive findings in this study that indicated that, overall, child welfare organisations in the KwaZulu-Natal region have responded positively to a certain extent to the challenge of HIV/AIDS in the broad areas of:

- ⌘ Policy implementation and modification.
- ⌘ Specific programmes for children.
- ⌘ Special facilities for children affected by HIV/AIDS.
- ⌘ Awareness and prevention programmes.
- ⌘ Community Projects.

And have not succeeded in the specific areas of:

- ⌘ Providing adequate care, support and counselling with regard to children and families infected and affected by HIV/AIDS.
- ⌘ Staff adequacy and training
- ⌘ Facilities for Pre and Post test counselling

Some of the factors that have been responsible for impeding the overall success can be attributed to:

- ⌘ High staff turnover
- ⌘ High caseloads
- ⌘ Burnout and stress
- ⌘ Lack of adequate resources
- ⌘ Inadequate funding
- ⌘ Lack of governmental support
- ⌘ Poverty
- ⌘ Negative factors regarding social security

**Policies that have been modified or implemented to address the psychosocial and economic consequences of HIV/AIDS.**

Although less than 40% of the child welfare organisations indicated that they are providing incentives or team building morale to support social workers, almost no provisions are made for social workers to address burnout and stress and staff turnover.

Katry (1981) as cited by Gillespie (1987:55) stated that one of the most common reasons for job dissatisfaction is the belief that work has no significance and that the individual's potential for increased self-actualisation and growth is not being stimulated.

Fifty percent of the respondents indicated that social workers have direct access to knowledge and resources regarding HIV/AIDS. This reflects that organisations are responding to the need for resources and knowledge revolving around HIV/AIDS. However, given the extent of HIV/AIDS and its enormous implications, one would expect all child welfare organisations to have access to training and knowledge.

Although child welfare organisations are embracing the developmental approach, the majority of the respondents reflected that change in terms of developmental welfare is taking place at a slow pace.

Almost 41% of the child welfare organisations stated that they are able to find cost effective ways of utilising existing resources.

In terms of being 'multi-functional' an overwhelming majority of respondents (almost 90%) indicated that being 'multi-functional' is difficult to achieve within child welfare organisations.

For the period of 2004, majority of the organisations (84.1%) rendered services to AIDS infected children and affected (93.2%) children. The total number of services rendered to infected children amounted to 1930 and the total number of affected children amounted to 16609 for the period of 2004. These numbers indicate that child welfare organisations are rendering services to AIDS infected and affected children in large and increasing numbers thus policy changes are critical in terms of effective service delivery.

In response to organisations having trained staff in the field of HIV/AIDS, (68.2%) found that the agencies do not have trained staff to render these services. Thus one can conclude that a large number of agencies do not have trained staff to deal with HIV/AIDS and child welfare organisations are not responding positively in this regard.

In terms of child welfare organisations' response to having special facilities such as children's homes, community homes, foster care and adoption for children that are affected by HIV/AIDS, the combined responses indicated that they are making concerted attempts to facilitate this and an overall success was reflected in the area of foster care. These responses will be discussed in more detail under question five.

With regard to therapeutic support services being offered by child welfare organisations as part of agency policy the main findings of the 3 categories are as follows: In response to memory box as a therapeutic support service, almost 25% of the respondents indicated that this was offered. With regard to therapeutic family sessions, the results indicate that almost 40% of the respondents offered this service. Bereavement and counseling was utilised by almost 45% of the respondents. It was interesting to compare the three therapeutic support services and it was found that of the three, bereavement and counseling was practiced in almost half of the child welfare organisations, whilst the memory box as a therapeutic support service was the least practiced.

The study suggests that in majority of the agencies provisions for Pre and Post Test counseling with regards to youth were not available. This will be further elaborated in relation to question five.

It was found that over 70% of child welfare organisations indicated that they offer awareness and preventative programmes for the youth.

Almost 50% of the organisations stated that specific programmes are in place to cater for HIV/AIDS affected children. The range of these programmes will be discussed in question four.

The findings indicated that almost 50% of the organisations were able to focus and actively engage in community-based projects. These ranged from women empowerment groups, adult education training, eco-gardening, sewing, poultry farming, crèches, arts and crafts, block making, volunteer recruitment and training, shelters, drop in facility, mat making.

The study reported that 50% of the child welfare organisations were promoting community care rather than institutional care. This indicates that child welfare organisations are moving away from the 'welfarist' method of practice.

Germane to the study was that 40.9% of the participants indicated that volunteers are trained to deal with HIV/AIDS. This points out that despite inadequacy of staff and lack of funding, some organisations are making concerted attempts to address the HIV/AIDS pandemic. It was interesting to find that fifty percent of the organisations are pursuing the option of focusing on men as primary caregivers instead of only women. This is an important aspect to policy changes in terms of women always taking on burden of care and stereotyped in the traditional role.



The results indicate that 37 respondents (84.1%) stated that they have not been successful in recruiting black families for adoption while only 6 respondents (13.6%) indicated that they have been successful in recruiting black families for adoption. This finding will be elaborated in question Six.

In summary regarding policy implementation within organisations, one can conclude that child welfare organisations have implemented and modified policies that incorporate HIV/AIDS with regard to rendering of services. However an important suggestion from one organisation is that an emergency policy and implementation must be put into action so that all child welfare organisations can work in a uniform manner so that efforts in the arena of HIV/AIDS pandemic are more meaningful.

#### **The availability of staff adequacy and training capacity to cope with HIV/AIDS in KwaZulu-Natal.**

The results indicated that almost 70% of the organisations found that they do not have trained staff to render services to children and families affected by HIV/AIDS. One reason for this is that high staff turnover leave organisations without trained staff as stated by some of the participants.

Another important finding related to this is stating that almost 82% do not have adequate staff to render services to children and families affected by HIV/AIDS.

The employment of an AIDS coordinator is also an important component of staff adequacy and training. The results indicate that an overwhelming majority (almost 90%) of child welfare organisations in KwaZulu-Natal do not have an AIDS coordinator. Respondents who stated that there should be an employee to deal with HIV related issues also reflected this. However, the study was able to show that almost 50% of the organisations indicated that they train social workers to working in the field of HIV/AIDS.

In order to combat staff inadequacy the organisations have resorted to utilising volunteers to assist in some aspects of service delivery. The results indicate that almost 41% of the organisations train volunteers to deal with HIV/AIDS, but a high proportion reflected that volunteers are not involved on an ongoing basis to provide services in the area of HIV/AIDS.

Burnout and stress are strong factors related to staff adequacy and retention as was indicated by majority of the participants. Maslach (1982) stated that the physically and emotionally exhausted care provider is no longer able to maintain the involvement expected in a helping relationship.

Salaries are also important in relation to staff adequacy. According to Banhorst (1989), although social work has moved in the direction of professionalism compared to the past, its workers should receive salaries large enough to permit them to maintain a professional standard of living, comparable to other groups requiring similar amount of education and training and sufficient to compensate for the cost of their preparation. The salary situation is also a misfortune from the point of professional prestige and is also linked to staff turnover.

#### **Programmes availability to children and their families affected by HIV/AIDS**

Almost 50% of the respondents indicated that they have specific programmes in place to cater for HIV/AIDS affected children, some of which include AIDS awareness programmes, support groups, child protection programmes, crèches, preschools and foster care recruitment programmes.

The results strongly indicate that child welfare organisations in KZN are responding to HIV/AIDS by offering programmes to affected children. It was found that of the 3 support services, bereavement and counseling is practiced in almost 50% of the organisations while the memory box is the least practiced. This indicates that child welfare organisations have incorporated therapeutic

support services as part of the agency policy, however some of them are experiencing difficulties in this regard.

### **Facilities provided for Pre and Post Test Counselling**

The results show that almost 90% of the respondents indicated that they have not made provisions for pre and post test counselling within child welfare organisations. This can be attributed to various factors, a crucial factor is lack of adequate funding and lack of staff. Some of the respondents indicated that there is a need for a specially trained individual to deal exclusively with HIV/AIDS related matters.

### **Facilities available for orphans**

The results indicate that facilities are offered in the form of Community Homes, Foster care and adoption. With regard to community homes, almost 82% indicated that they do not have this facility, 90.9% are offering foster care and 84.1% stated that they have not been successful in recruiting large numbers of black families for adoption.

The above findings are in accordance with the literature presented in Chapter Three regarding negative attitudes towards adoption that is still prevalent amongst numerous communities. However, some of the the positive responses indicate that attitudes are changing to a certain extent. Some of the reasons for the success could be attributed to the fact that some organisations are changing their methods of recruitment and black families are being more open regarding adoption.

The results indicate that almost 80% of child welfare organisations have not engaged in out-reach campaigns to raise awareness about adoption in rural areas. This has an impact on recruitment and availability of adoptive parents as indicated in the earlier findings.

### **Implementation of awareness or prevention programmes**

In response to the awareness and prevention programmes a vast majority of organisations (70.5%) stated that they offer awareness and preventive programmes to the youth. These can be listed as follows:

- ⊗ AIDS awareness programmes
- ⊗ Drop-in-facility
- ⊗ Volunteer recruitment and training programmes
- ⊗ Facilitation of youth groups
- ⊗ Involvement of youth in drama with HIV/AIDS as a theme
- ⊗ Talks at schools, clinics and hospitals

As HIV/AIDS is mainly affecting the youth, child welfare organisations in KwaZulu-Natal are responding to this urgent and critical need.

### **Obstacles encountered by child welfare organisations in KwaZulu-Natal with regard to HIV/AIDS**

These findings are significant as they reflect the conditions and context within which child welfare organisations are functioning. The obstacles will be highlighted separately.

#### **1) Staff Turnover**

Staff adequacy has already been discussed under question three. Burnout and stress as reflected in the findings also plays a strong contributory role. Almost 78% of the organisations stated that social workers in their respective organisations suffer from burnout and stress, 95.4% indicated that AIDS has presented enormous challenges to their organisations which are already overburdened, under-resourced and overstretched.

#### **2) High Caseloads**

A total of 90.9% of respondents indicated that due to statutory work less time is afforded to the care and support of children affected by HIV/AIDS.

### 3) Lack of adequate resources

Lack of adequate resources was reflected by 70.5% of the respondents, as being a contributory factor towards the challenge of HIV/AIDS. Lack of adequate resources can contribute to frustrations and feelings of inadequacy in rendering of services to clients. According to Hasenfield cited in Gillespie (1987:15), "the human service organisation is dependant upon the environment for the resources to maintain service delivery. If the resources are inadequate to maintain quality of service expected by the caregiver, this can result in burnout and stress." In addition, limited resources could have serious negative consequences in an already crisis situation.

### 4) Lack of adequate funding

A total of 77.3% of the respondents indicated that funding was inadequate in terms of coping with the challenge of HIV/AIDS.

### 5) Lack of government support

A total of 56.8% of the organisations indicated that the government has not been supportive. This indicates that government support is prevalent in some organisations but absent in others as indicated by one respondent who stated, "the department of welfare must fund all efforts to address and recognise the strengths of the private sector to meet challenges." In addition, 90.9% of the respondents agreed that if government was more cooperative and worked in partnership with NGOs their organisations would be better equipped in dealing with children affected and infected by HIV/AIDS.

Critics have argued that despite AIDS deemed to be the biggest threat to South Africa, and that while South Africa is the best equipped African country to respond to the AIDS crisis and has the strongest economy and infrastructure, its response has been slow and complacent. According to HEARD (2004), the TAC believes that the primary reason for failure to meet the target to implement programmes is the lack of political will. In addition implementation of GEAR has

not taken into account the devastating impact of HIV/AIDS on the country as a whole. Although the response to socio-economic challenges facing South Africa has been characterised by massive policy and legislative reform, much of what already needs to be done is already in place in policy. The challenge lies in implementing those policies and strategies and in monitoring and evaluating their appropriateness and effectiveness in the context of the epidemic. Most important is as strong commitment and will on the part of the government to fight HIV/AIDS.

#### 6) Poverty

An overwhelming majority of the respondents (97.7%) indicated that the poor economic conditions in South Africa have a direct impact on the welfare sector. According to the Taylor Committee of Inquiry (2002:70), "poverty is linked to the labour market. Unemployment was increasing from 33% in 1996 to 37% in 2001 to 41.8% in 2002. Thus the numbers of people experiencing poverty was also increasing. According to the Poverty and Inequality Report in South Africa (2003:41-43), "the total number of poor people in 2002 was estimated to be 21.9 million. " Poverty is an important phenomenon that child welfare organisations have to deal with on a daily basis especially against the context of HIV/AIDS.

#### 7) Inadequate social security and grants

In terms of the responses, 45.5% agreed that child support grants would reduce some of the burdens on child welfare organisations.

The government has acknowledged the challenges of a persistent structural unemployment problem and associated household poverty and therefore initiated efforts such as social security (Department of Finance, 1998:1.3). The government accepts that a well-targeted and well-managed social security can play an important role in meeting basic needs and alleviating poverty. However, Government has to date resisted calls from progressive civil society groups for a basic income grant.

These findings support the contention that child welfare organisations are experiencing strong obstacles with regard to their fight against HIV/AIDS.

### **Other important findings**

#### Demographic Differences

The participants included 20 child welfare organisations from urban areas including 4 servicing rural areas and 23 organisations from rural areas. Some of the significant findings in terms of rural urban differences are outlined as follows.

- 1) A larger proportion of urban areas compared to rural areas indicated that government was a contributory role player in terms of government support.
- 2) Child welfare organisations in urban areas receive more support from National Council of Child Welfare than those in rural areas.
- 3) In terms of trained staff there exists a higher inadequacy in rural areas compared to urban areas.
- 4) Although adequate funding from government was not a contributory factor for both urban and rural areas, it was found that funding is available to a slightly greater extent in urban areas than in rural areas.
- 5) Rural organisations experienced greater difficulty in recruiting volunteers than urban areas.
- 6) Although resources are inadequate in both rural and urban child welfare organisations, the level of inadequacy was even greater in rural areas.
- 7) In relation to specific programmes for AIDS affected children, there was a distinct difference between rural and urban areas, in that urban areas have a higher tendency for specific programmes than child welfare organisations situated in rural areas.
- 8) The results regarding organisations utilising therapeutic services indicate that urban areas are more prone to using the memory box as a therapeutic service to a slightly larger extent than rural organisations.

Family therapeutic sessions in urban areas are utilised twice as much than rural areas thus there is a clear rural-urban difference. The findings in terms of utilising bereavement and grief counseling is interesting as 4 times as many child welfare organisations in rural areas use bereavement counseling as a therapeutic service than child welfare organisations from urban areas.

- 9) There existed only 1 AIDS coordinator in the child welfare organisations in rural areas compared to 4 in the urban areas.
- 10) The results also indicated that a higher proportion of social workers in the urban areas have access to resources and knowledge regarding HIV/AIDS compared to rural areas.
- 11) There existed no distinction between rural and urban areas in focusing and actively being involved in community projects.
- 12) Regarding the level of qualification and position held within an agency, the results did not demonstrate any significant difference.

The results indicate that there exists a slight bias in urban areas rather than rural areas in that urban areas are at an advantage in terms of resources and support compared to rural areas.

### **Recommendations of the Study**

The combination of methods in terms of the open and closed ended questions and interviews facilitated valuable recommendations for further endeavours in the field of HIV/AIDS and child welfare organisations. Recommendations were identified from participants and from the review of the literature.

The main recommendations formulated by the participants from child welfare organisations in the KwaZulu-Natal region are briefly summarised as follows:

- ☞ Resource availability and accessibility need to be addressed.



- ⌘ Adequate funding is necessary.
- ⌘ Government support in addressing poverty.
- ⌘ Increases of salaries and funding need urgent attention as it impacts on service delivery.
- ⌘ Remuneration of volunteers to be considered as this will enhance community support. There exists a demand for more volunteers and training of volunteers.
- ⌘ Staff turnover is a critical problem and has serious consequences for rendering effective service especially in view of the HIV/AIDS pandemic. There is an urgent need for subsidisation of additional posts. Related aspects such as working conditions of staff and burnout and stress must also be addressed.
- ⌘ Respondents pointed out the need for an employee to be involved only with AIDS related issues at every child welfare organisation
- ⌘ Paraprofessionals must be employed to assist social workers with tasks such as documentation, application and processing of grants.
- ⌘ Advocacy on the part of child welfare organisations for institution of an across the board basic income grant as it would reduce the bureaucracy and fraud involved in the existing grant system
- ⌘ Issues regarding grants were highlighted. These included:
  - 1) Grants should be accessible to all parents who live in poverty
  - 2) The child support grant needs to be increased
  - 3) BIG should be introduced and made accessible to all families
  - 4) Grants to be available to child headed households.
  - In relation to community programmes more emphasis should be on:
    - 1) Targeting schools with prevention programmes.
    - 2) Educating grandparents in dealing appropriately with those infected and affected.
    - 3) Education of community members.
    - 4) Stigma of HIV/AIDS to be addressed.

- ⊗ Regarding legislation and policy the following recommendations are summarised:
  - 1) Child legislation and policies must include provision for children
  - 2) The gap between policy and practice must be narrowed.
  - 3) An emergency policy and implementation plan must be put into action so that all child welfare organisations can work in a uniform manner so that efforts can be more meaningful.
- ⊗ Networking and coordination amongst various organisations must be facilitated.
- ⊗ Child welfare organisations need to find creative strategies to deal with the pandemic and pointed out the need to embrace the developmental approach for more involvement of community projects.

The following section provides further recommendations in relation to research, policy and practice.

## **Research**

The study indicates that there are several possibilities for further research in the field of child welfare organisations and HIV/AIDS. The research topics proposed should increase professional leverage and lead to more effective and efficient practice. These opportunities include the following:

- ⊗ A follow-up study in 2010 and thereafter every 5 years to reassess the impact of HIV/AIDS on child welfare organisations in KwaZulu-Natal in terms of the escalating numbers of orphans, to ascertain whether policy or legislation have led to improvements in service delivery and to investigate whether the recommendations suggested in this study have been exercised and if so, to what extent has it impacted positively on its functioning.

- ⌘ Similar research to be conducted within all provinces and a comparative analysis be formulated to address the challenges facing child welfare organisations on a national level.
- ⌘ Further research on the same topic but focus on the qualitative approach to gain in-depth knowledge on some of the issues addressed.
- ⌘ A comparative research focusing on differences between rural and urban child welfare organisations and the reasons for the differences.

## Policy

Policy sets the foundation for effective practice within child welfare organisations. The following are some suggestions:

- ⌘ All child welfare organisations should formulate a uniform policy regarding its functioning whereby the AIDS component constitutes an important aspect of the policy. This should be a consultative process, which includes an equal and broad representation for all child welfare organisations.

This policy should provide clarification in terms of:

- 1) Programmes, facilities and support services for children
- 2) Training of social workers
- 3) Setting norms and standards terms of caseloads and working conditions for social workers
- 4) Staff retention policy
- 5) Incorporate staff support services and incentives as burnout and staff turnover are significant factors in rendering effective services.
- 6) Advocacy policy in relation to clients.
- 7) Policies addressing the gendered burden of care.

As a policy, government must subsidise the vacancy of an AIDS Coordinator specifically for all child welfare organisations. The functions and responsibility should include the setting up of an AIDS unit. The government to further

subsidise these posts and programmes as required. Failing the above, funding should be granted to all child welfare organisations to facilitate the above.

The government to provide adequate support structures, funding and clear guidelines for policy in order for social workers to respond to the call to engage themselves in wider socioeconomic arenas to change the circumstances of the poor and disadvantaged.

The state to reassess the developmental model and to formulate guidelines for intervention by combining the clinical and developmental paradigms for appropriate rendering of services including the neglected aspect of therapeutic counselling.

As community based programmes is an appropriate response to the care of orphans as indicated by the success rate of other countries such as Malawi and Uganda, the community care programmes needs to be replicated at a national level if it is to make a national impact on the AIDS epidemic.

## **Practice**

As HIV/AIDS is eroding progress in all aspects of society, it is also eroding structures within child welfare organisations in terms of its practice and functioning on a day-to-day basis. The following are some suggestions for practice against the devastating background within which social workers in child welfare organisations have to function:

- ⊗ The issue of HIV/AIDS itself and its impact has to be addressed within and across child welfare organisations and with government to develop effective strategies for practice.
- ⊗ It is important for all social workers to be trained in the field of HIV/AIDS.

- ⊞ Management of child welfare organisations to take cognisance of the burnout and staff turnover and employ good practice methods.
- ⊞ Child welfare organisations to advocate their plight and issues via the media and community for increased funding.
- ⊞ Creative strategies need to be found within child welfare organisations to deal with issues regarding HIV/AIDS.
- ⊞ Focus on group work and community work in addition to casework in order to cope with the increasing numbers.
- ⊞ Network with other organisations in the community for support services.
- ⊞ Create a yearly platform for all child welfare organisations to address practical ways of responding to the challenge of HIV/AIDS and other issues pertaining to service delivery
- ⊞ Increase of salaries and enhance the status of the professional workers to attract and retain social workers
- ⊞ Improved conditions of service for social workers
- ⊞ Set up an Employment Assistance Programme for social workers. This can be manned whereby one unit services 5 organisations.

As social workers are stressed by the very nature of their functioning it is imperative that support, staff development and debriefing be available for social workers themselves.

Finally, the answer to the challenge of HIV/AIDS lies in the AIDS crisis itself. In the absence of a cure the political will is crucial and vital to halting this epidemic. The roll –out of anti-retroviral drugs via a stronger commitment by government will ensure that parents are able to live longer to take care of their children.

## **Conclusion**

Child welfare organisations have traditionally been concerned with the service needs of children and their families when parenting functioning was impaired or, when the child was unable to function adequately within a family setting. The challenge of HIV/AIDS was not included in the traditional function of child welfare organisations.

Today, HIV/AIDS has become one of the most destructive diseases in the history of humankind including South Africa, which has an infection rate of 5 million and has one of the worlds' highest rate of infections in the world. Critics attribute the escalating figures to complacency and lack of political will.

Although the statistics seem grim and depressing and we seem defenseless against this scourge, child welfare organisations in KwaZulu-Natal have made significant and positive strides towards responding to the epidemic despite various challenges and obstacles. In view of the escalating numbers of children and families affected by HIV/AIDS, child welfare organisations have not been complacent and have taken decisive action and practical steps to render effective services in making a difference. However, time is running out. Child welfare organisations have been impacted by this pandemic in ways that one cannot begin to comprehend. As indicated in the study HIV/AIDS is already gaining a foothold and if changes are not forthcoming, it is indeed frightening to think how child welfare organisations are going to function in the future.

This study has answered questions regarding the responses of child welfare organisations in the KwaZulu-Natal region to the challenge of HIV/AIDS. It is hoped that child welfare organisations will benefit from the findings and recommendations in addressing and coping with the challenge of HIV/AIDS.

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# APPENDICES

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24 March 2005

**THE DIRECTOR**

Dear Sir or Madam,

**RE: QUESTIONNAIRE-RESPONSES OF CHILD WELFARE ORGANISATIONS  
IN KWAZULU-NATAL TO THE CHALLENGE OF HIV/AIDS.**

I respectfully would like to request you to complete the attached questionnaire, which will take about 20 minutes of your time.

I am aware of the time constraints and challenges faced by you in terms of service delivery on a day-to-day basis.

I am presently a practicing social worker within a child welfare organization and a master's student engaged in studies in Welfare Policy. I am working independently on this research project, however, with the knowledge of my field placement agency and permission from the School of Social Work and Community Development, University of KwaZulu- Natal, Howard College Campus.

The purpose of this research study is to learn more about how child welfare organisations are coping with the current impact of the HIV/AIDS pandemic in addition to its existing challenges.

Please be assured that confidentiality and anonymity will be maintained, as one of the objectives of the research is to assess the overall responses of the organizations and not targeted to individual organizations.

I plan to share the results with professionals within the field of Welfare and other related fields through presentations and publications.

The completed questionnaire can be mailed to:  
Husheila Gordhan  
Research Questionnaire  
P.O.Box 11262  
Marine Parade  
KwaZulu Natal  
4056.

If you do have any questions about the study, do not hesitate to contact me on (031) 3129313 or 083 457 6238.

Also if you are interested in the results of the study, please let me know.

It would also be appreciated if the completed questionnaire were mailed to the above-mentioned address **before 30 April 2005.**

I thank you once again for taking time off your busy schedule and for your valuable participation and important contribution.

Yours Faithfully

Husheila Gordhan  
(Social Work Masters Student)

30 May 2005

THE DIRECTOR

Dear Sir/Madam,

**RE: FOLLOW UP TO QUESTIONNAIRE-RESPONSES OF CHILD WELFARE ORGANISATIONS IN KZN TO THE CHALLENGE OF HIV/AIDS.**

I refer to my letter and questionnaire dated 24 March 2005.

I once again would like to appeal to you to complete the attached questionnaire.

Although the initial response date was 30 April 2005, I have extended the date to 30 June 2005 due to serious time constraints and challenges faced by some organizations.

It is both vital and significant that the returned questionnaire be completed and posted to me, as it will have a direct impact on the results.

In addition, in order to address the challenges faced by all the child welfare organizations in KZN, your participation is of great importance.

Attached please find my initial letter and questionnaire.

I once again appreciate your valued time and contribution.

Thank you

Yours faithfully

Husheila Gordhan  
Work 031-3129313  
Cell 083 457 6238



**QUESTIONNAIRE**KINDLY INDICATE YOUR RESPONSE WITH A TICK. ☒

1a) What is your position within the agency?

Director

☐

Deputy Director

☐

Senior Manager

☐

Manager

☐

Social Worker

☐

b) How long have you been in the present position?

0-5 years

☐

6-10 years

☐

11-15 years

☐

16 years +

☐

c) What are your qualifications?

d) Briefly mention your work experience.


e) The agency is situated in the following demographic area.

URBAN

☐

RURAL

☐

2) Does your organization employ a HIV/AIDS Co-ordinator/Facilitator?

YES

☐

NO

☐

3 a) Our agency renders services to HIV/AIDS infected children.

YES

NO

b) Our agency renders services to HIV/AIDS affected children.

YES

NO

4 Our agency has adequate staff to render services to children and families affected by HIV/AIDS.

YES

NO

5 As part of agency policy all social workers are trained to work in the area of HIV/AIDS.

YES

NO

6 Social workers in our agency have direct access to knowledge and appropriate resources applicable to children affected by HIV/AIDS in KwaZulu Natal.

YES

NO

7a) As part of agency policy specific programs are in place to cater for HIV/AIDS affected children.

YES

NO

b) If YES list these programs.


8 Our agency has special facilities for children that are affected by HIV/AIDS. These are:

a) CHILDRENS HOMES



b) COMMUNITY HOMES



c) FOSTER CARE



d) 1) OTHER



2) Briefly describe


9 a) Are any provisions made for Pre and Post Test Counselling with regards to the youth within your organization?

YES

NO

b) If not, are they encouraged to be referred for VCT?

YES

NO

10 In terms of agency policy we offer awareness and preventive programs with regard to HIV/AIDS to the youth.

YES

NO

11 Therapeutic support services as part of agency policy are offered to children affected by HIV/AIDS. Some of which include:

	YES	NO
a) Memory box	<input type="text"/>	<input type="text"/>
b) Therapeutic Family Sessions	<input type="text"/>	<input type="text"/>
c) Bereavement and Grief Counselling	<input type="text"/>	<input type="text"/>
d) Other	<input type="text"/>	<input type="text"/>
e) If other, please specify		


12 a) Our agency engages in training of volunteers to deal with HIV/AIDS.

YES	<input type="text"/>	NO	<input type="text"/>
-----	----------------------	----	----------------------

b) Volunteers are involved on a regular and ongoing basis to provide services in the area of HIV/AIDS.

YES	<input type="text"/>	NO	<input type="text"/>
-----	----------------------	----	----------------------

13 a) Our agency has a separate section/unit focusing exclusively on HIV/AIDS?

YES	<input type="text"/>	NO	<input type="text"/>
-----	----------------------	----	----------------------

b) What is the main purpose of this unit?


14 The 'White Paper' for Social Welfare exhorts service providers to 'maximise existing potential' i.e. to find cost effective ways to utilize resources. This has been practical and achievable with our organization.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

15 The change in terms of a more developmental approach is happening very slowly within our organization thus social workers continue to be perceived as providers of material assistance within our organization.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

16 If the government was more cooperative and worked in partnership with NGO's, our organization would be better equipped to deal with children infected and affected by HIV/AIDS.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

17 a) Our organization has been able to focus and actively engage in community based projects.

YES	<input type="text"/>	NO	<input type="text"/>
-----	----------------------	----	----------------------

b) If YES name some of the projects.


18 The following has been contributory factors/role players towards coping with the challenge of HIV/AIDS.

	YES	NO
a)Government Support	<input type="text"/>	<input type="text"/>
b)National Council for Child and Family welfare	<input type="text"/>	<input type="text"/>
c)Adequate Funding	<input type="text"/>	<input type="text"/>
d)Trained Staff	<input type="text"/>	<input type="text"/>
e)Volunteers	<input type="text"/>	<input type="text"/>
f)Resources	<input type="text"/>	<input type="text"/>

Other


19 The poor economic conditions in South Africa have a direct impact on the welfare sector, including our organization.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

20 Access to Childcare support grants has reduced some of the burdens on child welfare organizations.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

21 Our organization has been able to promote "community care" rather than "institutional care." with regards to children affected by HIV/AIDS.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

22 Many experts in the field of HIV/AIDS stated that the Aids pandemic is presenting enormous challenges to an under sourced and over-stretched welfare sector. This is this applicable to our organization.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

23 Less time is afforded for the care and support of children affected by HIV/AIDS as a result of the agency already being overburdened and overwhelmed by statutory work.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

24 NGO's often need to alter their focus as new challenges arise and may need to be 'multi-functional' i.e. provide care and welfare whilst also promoting change and development. Our organization sometimes experiences difficulty in this regard.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

25 High staff turnover in child welfare organizations play a negative role in terms of effective service delivery.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

26 Parity of salaries among all social workers i.e. state and private would have a positive impact in terms of rendering services to HIV/AIDS affected children.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

27 a) Social workers at our organization suffer from burnout and stress.

YES	<input type="text"/>	NO	<input type="text"/>
-----	----------------------	----	----------------------

b) Our agency provides incentives/team building morale to support the social workers.

YES	<input type="text"/>	NO	<input type="text"/>
-----	----------------------	----	----------------------

28 Our organization is not equipped with resources to meet the challenges confronting grandparents in the face of HIV/AIDS.

Strongly Disagree	Disagree	Agree	Strongly Agree
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

29 a) Our organization has not been successful in recruiting large numbers of Black families as adoptive parents.

YES	<input type="text"/>	NO	<input type="text"/>
-----	----------------------	----	----------------------

b) Our organization has not been successful in recruiting large numbers of Black families for children affected by HIV/AIDS.

YES	<input type="text"/>	NO	<input type="text"/>
-----	----------------------	----	----------------------

c) Our organization has not been successful in recruiting large numbers of Black families for children infected by HIV/AIDS.

YES	<input type="text"/>	NO	<input type="text"/>
-----	----------------------	----	----------------------



30 Our organization has been engaged in out-reach campaigns to raise awareness about adoption in rural areas.

YES

NO

31 If government introduced adoption allowances this will this have a positive impact on the recruitment of adoptive families for:

a) Children affected by HIV/AIDS.

Strongly Disagree

Disagree

Agree

Strongly Agree

b) Children infected by HIV/AIDS.

Strongly Disagree

Disagree

Agree

Strongly Agree

32 a) Women have traditionally been the primary caregivers of children. The focus needs to change to men as primary caregivers.

Strongly Disagree

Disagree

Agree

Strongly Agree

b) If Agree/Strongly Agree our organization has not been involved in pursuing this option.

YES

NO

33 Approximately how many:

a) Children infected by HIV/AIDS did your organization work with in 2004?

b) Children affected by HIV/AIDS did your organization work with in 2004?

c) Adults infected with HIV/AIDS did your organization work with in 2004?

\_\_\_\_\_

My recommendations in terms of coping with the Aids pandemic within child welfare organisations are:

[illegible]

P.O.BOX 11262  
MARINE PARADE  
DURBAN  
4056

DATE: 25 JANUARY 2006

THE DIRECTOR  
DURBAN CHILDREN'S SOCIETY  
DURBAN

DEAR MADAM,

RESPONSES OF CHILD WELFARE ORGANISATIONS TO THE CHALLENGE OF  
HIV/AIDS IN KWAZULU-NATAL

In 2005, I embarked on an independent research study, mandated by the University of Kwazulu-Natal, which was part of my masters program. The focus of the study was on the responses of child welfare organisations to the challenge of HIV/AIDS in KwaZulu-Natal.

Mailed questionnaires were sent to all the child welfare organisations in KwaZulu-Natal and despite various organizational challenges, a very high response rate was received.

Certain key areas of concern were highlighted by the organisations and it was decided that as part of the final phase of the study, it was critical that personal interviews be held with some of the organisations to discuss important areas of concern regarding the HIV/AIDS pandemic.

I am fully aware of the time constraints, the high caseloads and the persistent staff turnover, which adds to the daily stresses and affects the functioning of individuals on a daily basis. In the same token, I have to stress that the HIV/AIDS pandemic has affected child welfare organisations in ways one cannot even begin to comprehend.

I would contact you regarding an appropriate time for the interview.

The information shared will contribute significant value to the research findings and to the field of child welfare and HIV/AIDS.

Attached please find a guideline to some of the questions. There is no fixed format and you are at liberty to contribute whatever information you feel will be of interest to the topic on hand.

I once again thank you for your important contribution that will impact on the research findings positively and to contribute to the field of welfare as a whole.

Your co-operation is sincerely appreciated

Yours faithfully

Hushella Gordhan.  
Cell 083 457 6238  
Wk 031 3129313

## **GENERAL QUESTIONS FOR CHILD WELFARE RE: CHALLENGE OF HIV/AIDS**

- 1) What is your position within your organisations?
- 2) How long have you been in the present position?
- 3) How many years of service has been within a child welfare setting?
- 4) In light of the high staff turnover, there are a few individuals who are choosing to continue rendering services within the child welfare organisations. This reflects dedication, a deep sense of commitment and sacrifice. What are your reasons?
- 5) What are the different programs your organisations is involved in? Name some of them and describe them in detail.
- 6) What are some of the special facilities for children that are affected by HIV/AIDS?  
Such as foster care, children's homes, community homes etc.
- 7) What are some of the therapeutic support services offered?
- 8) What are some of the major policy changes that have been implemented in light of the HIV/AIDS pandemic?
- 9) Does volunteers constitute an important aspect of your organization?  
How does your organization recruit volunteers?  
Are they trained?  
Is it difficult or easy to train volunteers?
- 10) What are some of the different community projects? Can you describe them?
- 11) What are some of the challenges that your organization has faced in the light of the AIDS pandemic?
- 12) In terms of adequacy of staff, how has staff turnover impacted on your organisation?  
Is it possible to provide figures for resignations of staff for 2001, 2002, 2003, 2004 and 2005?  
What are some of the reasons for this?
- 13) What are your overall recommendations/views for child welfare organisations in terms of coping or responding to the HIV/AIDS pandemic?
- 14) In terms of adoption. Has your organization been successful in recruiting families for adoption? What about black families. Possible reasons.